STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966287	04/26/2017
NAME OF PROVIDER OR SUPPLIER **INN AT LA POSADA**	STREET ADDRESS, CITY, STATE, ZIP CODE **3600 MASTERPIECE WAY** **WEST PALM BEACH, FL 33410**	

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

0000 - Initial Comments

An unannounced Extended Congregate Care Monitoring visit was conducted on at The Inn at La Posada, an Assisted Living Faciltiy, located in West Palm Beach, license # 10600. The facility had deficiencies at the time of the survey.

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

Based on observation, record reviews and interviews, the facility failed to ensure that expired and/or discontinued medications were offered to the Family, Power of Attorney or Responsible Party within 30 days of being expired or discontinued for 2 of 2 medication . (ALF unit and Secure Unit).

Findings include:

1) On at 1:32 PM, the Surveyor asked the Medication Nurse to show the surveyor where expired and/or discontinued medications were stored. The nurse pointed to an open cardboard box which was located on a stack of cardboard boxes inside the medication . When asked what is done with the medications, the nurse stated, " When the Director of Nursing for the Skilled Nursing Unit comes over ,we give them to her. The Surveyor asked if the Responsible Party/ Power of Attorney for the resident was informed and offered the opportunity to pick up the medications. The Nurse confirmed that this is not done. The Nurse stated that he was unaware how long it had been since the Director or of Nursing had picked up the discontinued/ expired medications. The nurse confirmed that the medications were not secured and that anybody could walk into the , pick up the box and leave with the medications. The Director of Nursing walked into open Medication confirmed that she does not routinely check to see if there are expired and/or medications that need to be destroyed on a routine basis. She stated, " I haven't done that in a long time."

2) The Surveyor then walked to the unsecured unit along with the Nurse and the Medication Technician, responsible for administering medication on the unsecured unit. The cabinet was approximately 4 feet wide and 2 feet deep. When asked what occurs when a medication is expired or discontinued, the Medication Technician stated, " We put them in that cabinet (points to lateral filing cabinet). The technician was asked if the Responsible Party, Family Member and/or Power of Attorney were notified of the medications, she confirmed that they are not notified. She then stated that the DON will eventually pick up the medicatons for destruction, but that that has not happened in several months.

The surveyor opened the lateral filing cabinet and observed that it was full from top to bottom and side to side with medications in bottles, vials, cards and/o rboxes. A side by side accounting of the medications observed in the filing cabinet was conducted with the Nurse, Director of Nursing,

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Medication Technician and the Risk Manager for the Skilled Nursing Facility at that time. The following medications were confirmed to be over the 30 day period and should have been offered to family / reponsible party and/or destroyed :

1) 1 card of 500 mg 3 cards of , 81mg
2) 6 cards of , 325mg
3) 1 card of , 25mg
4) 4 cards of 100mg
5) cards of 600mg plus D 40mg
6) 1 cards of Donepezol 10 mg, 2 cards of er 120 mg
7) 2 boxes of vials
8) 2 cards of , 5mg
9) 2 bottles of Fish oil 1200 iu
10) 2 bottles of Florastor 25
11) 1 card of HCTZ 37.5mg
12) 1 bliser card of , 600mg, 1 card of Immodium 2mg, 6 cards of , 2mg
13) 2 card of Levothuyroxine 25mg
14) 1 card of Levorhyroxine 50mg
15) 1 bliseter card of 40mg
16) 1 card of Lotemax
17) 1 card of Lantoprost
18) 1 bottle of Magic Mouthwash (prescription)
19) 1 card of
20) 2 bliter cards of , 25mg
21) cards of , 15mg
22) 1 card of , 5mg
23) 2 bliseter cards of Patoprazole 40mg
24) 1 bottle of Thera M multi
25) 1 bottle of Theratears
26) 1 box of patches
27) 2 bottls of Relafen syrun
28) 2 card of
29) 2 cards of 75mg
30) 1 bottle of Eldertonic
31) 1 bottles of Robafen syruip
32) 2 bottles of Timonol drops and 2 boxes of

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The Director of Nursing stated that the facility would develop a system to inform family of the discontinued medications. The Director of Nursing confirmed that she was unaware that family and/or the responsible Party / POA should be notified when medications were expired or discontinued to determine if they wanted to pick them up. She also confirmed that when medications are destroyed, there is no documentation in the resident's clinical record.

Class III

E201 - ECC - Policies - 58A-5.030(2) FAC

Based on observation, record review and interviews, the facility failed to ensure that policies and procedures were developed to promote an extended congregate care program .

Findings include:

The surveyor entered the facility on an informed the Administrator that she was there to conduct an Extended Congregate Care (ECC) Monitoring visit. He was asked to provide the facilities policy and procedure (manual) for ECC. The Administrator confirmed at that time that the facility failed to develop and/or implement a ECC policy and procedure manual as required by the regulations.

Class III

E203 - ECC - Staffing Requirements - 58A-5.030(4) FAC

Based on record reviews and interviews, the facility failed to ensure that staff received extended congregate care training.

Findings include:

On at 3:38 PM, the Surveyor requested evidence of staff training for Extended Congregate Care Services. The Administrator confirmed that he had not completed the required 4 hours of ECC training and that no training had been provided to any of the direct care and/ or nursing staff regarding the Extended Congregate Care (ECC) . The Administrator confirmed that the facility had failed to designate an ECC Supervisor; therefore none of the staff had the required training. The Administrator stated that Nurse A was scheduled to attend Core Training in the future and would then be designated as the ECC Supervisor.
During an interview with Staff B, when asked if she would like any additional training, Staff B stated,

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"Yes, I would like to have ECC training."

Class III

E205 - ECC - Health Assessment - 58A-5.030(6) FAC

Based on record reviews and interviews, the facility failed to ensure that a resident designated as receiving Extended Congregate Care Services had a Health Assessment completed, for 1 of 1 sampled residents (Resident # 1)

The Findings include:

Upon arrival at the facility on at 12:15 PM, the surveyor asked the Administrator if there were any Extended Congregate Care (ECC) residents in the facility. He summonsed the Director of Nursing (DON) at the attached Skilled Nursing Facility, who was also the DON at the facility, She stated, "Well, I guess Resident # 1 as he is provided intermittent cathteterizations on a fixed schedule.

A review of the clinical record of Resident # 1 revealed that he was admitted to the facility on . The surveyor reviewed the AHCA 1823 Health Assessment dated which documented that the resident only required supervision with toileting. The Health Assessment form did not document that Resident # 1 required intermitted suprapbic .Further review revealed that the resident had a Physicians order dated for intermitted every 8 hours and was changed to every 12 hours on . There was no evidence that a new 1823 assessment/form was completed after the initial one on .

The surveyor asked the Director of Nursing on at 450 PM when Resident # 1 was placed on ECC Services. The DON stated that he went on ECC when we got the order to start scheduled intermitted on . The surveyor asked the DON if a request for a new 1823 had been conduced and /or if there was evidence that the resident was reassessed after . The DON confirmed that the facility failed to ensure that the resident was reassessed after being placed on ECC services and that the only 1823 form in the resident's clinical record was the initial one of . The DON stated that she was unaware that a new health assessment was required either before or within 60 days of being admitted to ECC services.

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Class III

E207 - ECC - Services - 58A-5.030(8) FAC

Based on record reviews and interviews, the facility failed to ensure that a monthly nursing assessment was conducted for residents on Extended Care Services, for 1 of 1 sampled residents (Resident # 1)

The findings included:

The facility identified Resident # 1 as receiving Extended Congregate Care Service (ECC) due to the medical necessity of twice daily intermittent , , . The Resident began to receive these services on in accordance with the physician's order. There was no evidence in the resident's electronic record that a monthly nursing assessment was conducted.

An interview was conducted with the Director of Nursing (DON) on at approximately 3:35 PM. The DON was asked if a monthly Nursing Assessment was conducted and documented in the clinical record of Resident # 1. The DON stated that she was unaware that a monthly Nursing Assessment was required for ECC resident 's and confirmed that none had been conducted for Resident # 1. The DON confirmed that the facility failed to ensure that a monthly Nursing Assessment was conducted on Resident # 1 since being placed on ECC Services on .

Class III

E208 - ECC - Records - 58A-5.030(9) FAC

Based on record reviews and interviews, the facility failed to develop extended congregate care policies and procedures failed to document progress notes for 1 of 1 residents receiving extended congregate care services.

The Findings Included:

1) On at approximate 3:32 PM, the surveyor requested a copy of the facilities policies and procedures for Extended Congregate Care. The Administrator and Director of Nursing confirmed that the facility had not developed and/ or documented extended congregate care policies and procedures.

2) Review of the electronic clinical record for Resident # 1 revealed a Service Evaluation effective date . There was no evidence at the time of the survey that the resident agreed to the Service Plan Evaluation or explanation why one was not conducted upon admission to ECC services on . In

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addition, there was no evidence that monthly progress notes were documented in the clinical record.

An interview was conduced with the Director of Nursing (DON) on at approimately 3:32 PM. The DON was asked to provide evidence that monthly progress notes were documented in the clinical record of Resident # 1. The DON confirmed that the facility failed to document monthly progress notes for Resident # 1, who was admitted to to ECC services on . The DON confirmed that a service plan was not developed until and that it had not been reviewed and/or agreed to by the resident and/or responsible party. The DON confirmed that the facility does not have a procedure to ensure that a resident placed on ECC services will be notified of their service plan and that the facility does not ensure that the resident agrees to the plan.

Class III

E210 - ECC - Training - 58A-5.0191(7) FAC

Based on record review and interviews, the facility failed to ensure that the Administrator, Extended Congregate Care supervisor and direct care staff were provided training (in-service) in extended congregate care services, for 16 of 16 sampled direct care staff (Staff A, B,C, D, E, F, G, H, I, J. K, L, M, N, O, P) .

The Findings include:

On at 3:32 PM, the surveyor requested evidence of training in Extended Congregate Care (ECC) for direct care staff. The Director of Nursing(DON) provided a Class attendance record dated starting at 3:00 PM to 4:30 PM (1.5 HOURS) The signed attendance record revealed that employees B,F, H, I, N, J, K,O, P and M were in attendance. The Director of Nursing confirmed that the in-service/training did not meet the required 2 hours. The DON provided a second class attendance form dated starting at 3PM with no end time revealed that employees C, E, F and G. attended. The DON confirmed that the in-service was not a two hour in-service and that the facility failed to provide 2 hours of training on ECC serices for any of it's direct care staff.

The Administrator was also in attendance at that time and confirmed that he had not completed any ECC training and that there was not a designated ECC Supervisor at that time. He also confirmed that employee A, A Licensed Practical Nurse had not received ECC training, but was scheduled to attend Core Training in .

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Class III