STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966519	R 05/24/2017
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 follow-up to complaint investigation #2016014670 was conducted on through . In addition, Complaint investigations #2017003523, #2017002603 and #2017003875 and revisits for Complaint Investigations #2017003496, #2017000327, and #201613957 were conducted on the same dates.

Indigo Palms at Maitland Assisted Living, (License# 10704) had deficiencies pertaining to #2016014670 at the time of the visit.

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

DEFICIENCY REMAINED UNCORRECTED

Based on interview and record review the facility did not make every reasonable effort to ensure that a prescriptions for 3 of 26 sampled residents #20, #36 and #37 who received assistance with self-administration of medications, that the medications were filled timely.

Findings:

1. The MOR dated , 2017 for resident #20 listed , 5-325 mg one tablet twice daily @ 8AM & 5 PM and had staff initials on @ AM, @ 8AM & 5PM and @ 8AM. The back page of the MOR indicated that the medication was not available awaiting refill. The health assessment report dated indicated he needed assistance with self-administration of medications.

2. Resident #36 lived in the memory care unit. The health assessment report 1823 dated listed diagnoses of high , and . She needed assistance with self-administration of medications. A healthcare provider's order dated indicated the family requested mouth gel and an order was needed. The MOR dated , 2017 listed dry mouth gel apply to and , after meals @ 8 AM , 2 PM & 8 PM and had staff initials circled on 5/7 and 6/8 for all dosages, and 5/8 @ 8 AM & 12 PM. The back page of the MOR indicated that on 5/7and 5/8 for all dosages the gel was not applied because it as was not available/awaiting refill.

3. According to the health assessment, report 1823 dated resident #37 needed assistance with self-administration of medications. He lived in the memory care unit. A healthcare provider's order dated indicated tears one drop to each eye every 4 hours. The MOR dated , 2017 listed tears one drop to each eye every 4 hours at 9 AM, 12 PM, 4 PM and 8 PM. The MOR had staff

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initials circled on at four and 8 PM, for all dosages and 8 AM and 12 PM. The back page of the MOR indicated that eye drops were not given because the medication was not available/awaiting delivery on : @ 4 & 8 PM , @ 8 &12 PM , @ 8 AM &12 PM, @ 8 AM, 12 & 8 PM , @ 8 AM , 12 & 8 PM, 4 & 8 PM, @ 12 PM, and @ 8 AM & 12 PM.

There was no documentation in the resident's records (#20, #36 & #37) what actions the facility took to ensure the medications were refilled timely to ensure the residents did not miss any dosages of their medications.

In an interview on at 1:45 PM with staff N, a licensed Practical nurse and staff M who said, the residents' sons did not bring the medications.

Class III

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

DEFICIENCY REMAINS UNCORRECTED

Based on personnel record review and interview the facility failed to have evidence showing that 1 out of 5 sampled staff (K) had received required in-service training within 30 days of employment.

Findings:

Personnel record review revealed Staff K, hired as a CNA, had not received a minimum of 1 hour in-service training that covers the following subjects: Elopement response, Reporting major incidents, Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation and Nutritional and safe food handling.

In an interview with the Interim Resident Care Director on at 2:15 pm, she confirmed the training was not completed, and stated staff K did not show up for the in-service.

Class III

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

DEFICIENCY REMAINS UNCORRECTED

Based on personnel record review and interview the facility failed to have evidence showing that 1 of 5

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	AL11966519	R 05/24/2017

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INDIGO PALMS AT MAITLAND	**740 NORTH WYMORE ROAD** **MAITLAND, FL 32751**

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

sampled staff (G) who provided direct care to residents received required 's and Related (ADRD) Training.

Findings:

Personnel record reviews for Staff G, hired on revealed no documentation for the required annual ADRD update training. Staff G did complete Level I and Level II training in ADRD on .

In an interview with the interim Resident Care Director on at 2:15 pm, she confirmed Staff G did not complete the annual update. She further explained the former administrator chose to only train new staff after the citation and not go back and train others.

Class III

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

DEFICIENCY REMAINS UNCORRECTED

Based on personnel record review and interview, the facility failed to ensure 4 of 5 sampled staff (G, I, J, K) received 1 hour of training regarding ( ) within 30 days of hiring.

Findings:

Review of the personnel records for the following staff members G (hired), I (hired), J (hired) and K (hired) did not reveal documentation of completion of the required 1 hour of training in the facility's policies and procedures regarding within 30 days of employment.

In an interview with the interim Resident Care Director on at 2:15 pm, she confirmed the training had not been completed and stated the former administrator chose to only train new staff after the citation and not go back and train others.

Class III