STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966519	05/26/2017
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

Complaint investigation #2017003875 was conducted on , and . In addition, Complaint investigations #2017003523, and #2017002603 and revisits for Complaint Investigations #2017003496, #2017000327, # 2016014670 and # 201613957 were conducted on the same dates.

Indigo Palms at Maitland Assisted Living facility License #10704, had deficiencies pertaining to #2017003875 at the time of the visit.

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

Based on interview and record review the facility failed to ensure that 1 of 31 residents sampled was treated with consideration and respect and with due recognition of personal dignity (#3).

Findings:

In an interview with Resident #3 on at 11:20 AM, she stated the staff sometimes made her wait almost 3 hours to get her medications. She said that Staff V yelled at her after last weekend and said, "I'll call your doctor and you won't get any medicines anymore." if she did not stop complaining about her medicines. She said staff also told her that they "wrote her up" and said, "She took more pills than she was supposed to take." Resident #3 stated, "I don't know how I could do that when they have the keys." She said, "The new administration is not professional and does not respect us. They treat us like this is a mental hospital."

In a review of the Medication Observation Records (MOR) for , , and , 2017, on - on the 11pm to7am shift- resident #3 did not receive pain medication IR 30mg at 12 midnight as ordered. Also on the same shift, she did not receive , medication Alprozolam 1mg PRN at 12 midnight. The MOR is blank for both of these medications. There is no explanation on the back of the MOR. It is documented that she received the 6AM dose of both medications- the boxes are initialed by KH. On at 1:20 PM, Staff V said she could not explain why the resident did not get her medications or why the MOR did not have any comments, as this was before she was working at the facility.

In an interview on at 2:00 PM the Regional Director, he was informed of the above comments by the resident. He replied that resident #3 is always making up wild stories and told people there was a conspiracy with the last administration and now there is one with the new administration, too.

When informed he had to send Staff V home in light of the concerns voiced by 2 residents, he replied,

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"Well, we can't send everyone home."

Class III