STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969123	12/27/2017
NAME OF PROVIDER OR SUPPLIER **WELLNESS LIVING IN PLANTATION LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **221 NW 49TH AVE** **PLANTATION, FL 33317**	

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

0000 - Initial Comments

A Limited Nursing Service (LNS) monitoring visit was conducted on at Wellness Living in Plantation, an Assisted Living facility, License #13003. 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 the Assisted Living Facility (ALF) failed to ensure resident safety for 3 of 4 residents residing in the ALF, Resident #1, Resident #2 and Resident #3, as evidenced by metal shutters covering blocking egress to the outside in case of a fire or emergency situation.

The findings included:
On a hurricane passed through the area where this ALF home is situated. During a monitoring visit conducted on at 9:45 AM, the home was entered to reveal the back window of the living had a metal hurricane shutter covering the window. Upon entrance to the facility, Residents #1, #2 and #3 were observed sitting in the living resident interviews were conducted. Resident #4 was observed sitting outside on the back deck of the home. Further observation while outside, 2 windows on the back of the home were covered by bolted down metal hurricane shutters. Back inside the home, down a short hallway, a tour of Resident #2's this was blocked off to the outside by a bolted down metal shutter. Next to Resident #2's a shared , Resident #1 and Resident #3. This corner observed to have a window facing the back and a window facing the side of the home. Both windows were observed to be covered by bolted down metal shutters. In case of a fire or emergency situation, Residents #1, #2 and #3 would not have egress through their to the outside. Of note, the hurricane passed through the area over 2 months ago.

On at approximately 10:15 AM an interview was conducted with the Administrator apprising her if there was a fire in the hallway, Residents #1, #2 and #3 could not escape through their that are covered with bolted down metal shutters. The Administrator stated the metal shutters remained in place to show her insurance company she was using a , size of bolt to secure the shutters to the home. The Administrator was cautioned if there was a fire in the hallway outside Resident #1, #2 or #3's , they would not be able to escape through their resulting in a potentially dire incident. The Administrator acknowledged this was a safety issue and stated she will have the shutters removed.

Class III

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0031 - Resident Care - Third Party Services - 58A-5.0182(7) FAC

Based on observation, interview and record review the Assisted Living Facility (ALF) failed to ensure communication was maintained between a Home Health Agency and the ALF for 1 of 1 residents reviewed receiving home health agency services, Resident #1, as evidenced by the ALF failing to communicate with the Home Health Agency for Resident #1 related to the status of a .

The findings included:
On at 9:45 AM upon entrance to the facility, Resident #1 was observed with a gauze dressing to his left great toe. An inquiry was made to the Administrator if they have any residents currently under Limited Nursing Services to which she stated they do not and Resident #1's dressing is changed by a Home Health Agency nurse who comes in daily.

Review of the resident's record revealed an admission note dated written by the Administrator, documenting the resident has a , location not documented. Further review of the resident's record revealed no documentation of the status of the resident's left great toe .

Review of the Home Health Agency home chart revealed no documentation of the status of the by the Home Health Agency nurses.

On at 11:00 AM an inquiry was made to the Administrator of the status of Resident #1's to which she could not state what the status of the was at this time, only to say it looks like it is getting better. The Administrator stated the Home Health Agency nurse comes in daily and they would say something if the was not getting any better. The Administrator acknowledged there is no documentation of a description of the on admission, or a current description of the and it is their responsibility to know what is going on with their residents.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observation, interview and record review the Assisted Living Facility failed to ensure the accuracy of medication administration for 1 of 1 residents reviewed for medications, Resident #1, as evidenced by no Medication Observation Record (MOR) available for review and inaccurate medication administration and availability of medications for Resident #1.

The findings included:
A record review was conducted for Resident #1 at 10:20 AM on in the presence of the Administrator. Resident #1 was admitted to the facility on with diagnoses to include .

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failure, pace maker, , , and to the left great toe. While reviewing the 1823 Resident Assessment, special instructions were noted for the , documenting the dosage to be 15 mg twice daily until and then decreased to 20 mg daily starting on . Additionally, this order was noted on a hand written prescription in the chart. Further it was noted on the 1823 Resident Assessment, the medications , , with and milk of magnesia were not listed on the hand written prescription. A request was made to the Administrator to review Resident #1's MOR. Accompanying the Administrator to the medication cart, the Administrator stated she has not made up a MOR as yet and in , the MOR will be generated by the pharmacy. An inquiry was made how they know which medications are due and when and where they are documenting the medications were administered. The Administrator stated she received the medications from the pharmacy and some medications the resident arrived with from the rehab center and the frequency is documented on the packaging. The packaging for the was reviewed to reveal on , , , and the resident received 15 mg twice daily and not the 20 mg daily order to commence on . The Administrator stated they rely on the pharmacy to supply the correct medication and dose and she cannot explain how this could have happened. The Administrator was apprised if a MOR had been generated on the resident's admission on , this error could have been prevented. On at 10:50 AM, the Administrator called the pharmacy and spoke with the pharmacy director via speaker phone. The pharmacy director accessed Resident #1's records and stated the prescription was faxed to them on and the medications they sent reflected this date. The pharmacy director was not aware Resident #1 was admitted to the facility on . The Administrator asked why the pharmacy did not supply the , , with or the milk of magnesia and the pharmacy director stated they do not have those medications in their records and they prepared the medications according to the prescription that was faxed to them. The Administrator stated to the pharmacy director those 3 medications were listed on the 1823 Resident Assessment to which the pharmacy director stated an 1823 was not faxed to the pharmacy. An inquiry was made to the pharmacy director at this time asking if a facility normally faxes the 1823 along with any other prescriptions, to which he stated they do normally receive a copy of the 1823 and they use that to correlate the medications listed on the 1823 to any other prescriptions and if there are discrepancies or omissions, they will contact the physician for clarification. The Administrator asked the pharmacy director why they sent a pack of twice daily dosing from to to which he stated the is a titrated medication and they based the dosage on the resident's admission of . Regardless of the admission date, the physician's order was to decrease the dose from 15 mg twice daily to 20 mg once daily as of and an admission date of or is not relevant. Both the facility and pharmacy were in error of the ordered dosage and had a MOR been generated on the resident's admission, reading the dosage change on paper could have prevented the error. After the interview with the pharmacy director, the Administrator proceeded to review the medication packs and documented them on a MOR to reflect the rest of the month from through .

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