STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964771	**01/16/2018**
NAME OF PROVIDER OR SUPPLIER **ST MARY'S ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **7001 SOUTH DIXIE HIGHWAY** **WEST PALM BEACH, FL 33405**	

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

0000 - Initial Comments

An unannounced Relicensure survey was conducted on at St. Mary's Assisted Living Facility (License #9264). There were deficiencies found during the survey.

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation and interview, the facility failed to ensure that all staff followed the proper procedure when assisting with self- administration of medications for 4 of 5 sampled residents (Resident#6, Resident#7, Resident#8, Resident#9).

The Findings Included:

A medication pass observation was conducted on with Staff B between the hours of 11:20AM. The observation revealed at 11:20AM, Resident#6 requested as needed Aceminophen 325mg 1 Tab for pain four times a day and Pro-Air 90mcg inhaler, to be given 2 puffs every 6 hours. Staff B sanitized her hands, compared the Medication Observation Record (MOR) with the medication label, stated the name of the medication to the resident and gave the resident the medication in a medication cup. Staff B did not immediately sign the MOR. An audit of Resident#6's MOR was conducted at 11:20AM and revealed no signature for the remediation Staff B had given at 11:20AM.

A medication pass observation was conducted on with Staff B at 12:02PM. The observation revealed Resident#9 received the following medications: mg- 1 tablet twice a day as needed for pain, 600mg 1 tab by mouth every 8 hours, and 800mg -1 tablet every 6 hours. Staff B sanitized her hands, compared the MOR to the medication label. Staff B signed the MOR prior to giving the medication to the resident, and Staff B did not announce the medication to the resident.

A medication pass observation was conducted on with Staff B at 12:10PM. The observation revealed Resident#7 received the following medications: mg- 1 tablet four times a day as needed for pain, 15mg 1 tab by mouth three times a day, 300mg - 1 tablet three times a day, and Lorazaepain 1mg tablet by mouth daily. Staff B sanitized her hands, compared the MOR to the medication label. Staff B signed the MOR prior to giving the medication to the resident and Staff B did not announce the medication to resident.

A medication pass observation was conducted on with Staff B at 12:200PM. The observation revealed Resident#8 received the following medications: 0.25mg, 1 tablet three times a day, Capsules 300mg. 2 capsules four times a day, and Phentonin Sod Ext. 100mg capsule 1

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capsule by mouth three times a day. Staff B sanitized her hands, compared the MOR to the medication label. Staff B signed the MOR prior to giving the medication to the resident and Staff B did not announce the medication to resident.

During an interview with the Administrator on at approximately 2:00PM, she acknowledged the findings.

Class III

0151 - Physical Plant - Existing Facilities - 58A-5.023(2) FAC

Based on observation and interview, the facility failed to provide a safe, sanitary living environment, ensuring
all appurtenances are in good working order.

The Findings Included:

During observational tour conducted on at 10:27AM the following concerns were noted:

1). Observation of # revealed the bathtub had scratch marks throughout the inside base of the tub.

2). Observation of # revealed the door frame and entry door was in disrepair. Further review of # revealed the in has a commode chair over the toilet that had various rust stains in areas where the residents sits. A review of the shower revealed a rusted shower head, and at the base of the shower bed there is missing calking leaving a gap in the tile of the floor of the shower. There is also a hole in the wall of the shower.

3) Observation of 10, 11, 12, 14, 18 and 19 revealed no paper towels or paper towel holders in the .

During an interview with the Administrator on at 2:49PM she acknowledged the findings.

Class III.

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0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on interview and record review, the facility failed to provide, within 1 business day, an Adverse Incident Report to the Agency for Health Care Administration (AHCA) related to an event that was required to be reported to law enforcement and placed at resident at risk of harm and injury (Resident #2).

The Findings Included:

On during the entrance conference, the Administrator revealed that Resident#2 eloped form the facility on . The resident was missing for 3 1/2 hours and she was found safe and unharmed by her son across the street from the facility. The resident was taken to the hospital for observation and returned to the facility. The facility followed their elopement policy and procedures, and law enforcement was notified. A facility incident report was completed. Further record review revealed no adverse incident report was completed.

Record review of Resident #2's file revealed an admission date of with a history / diagnosis of - Stable over the past year 2013, , , and , . , the resident is easily in new surroundings. Nursing requirements documented as monitor for increased and observe for safety precautions. No risk for elopement or exit seeking behavior documented. The resident is independent with all ADL"s and requires supervision on ambulation.

A review of the residents observation notes contain no documentation of Resident#2 being exit seeking at any time prior to the incident. The elopement was documented in the observation notes and stated the resident was observed in the dining , TV on at 10:45AM. Hourly rounds was conducted at 11:45AM and the resident could not be located. The facility and surrounding area was searched, the Administrator, the Power of Attorney and law enforcement was notified. Further review revealed a facility incident report was completed that documented the details of the elopement and Resident#2 was located by her son across the street at a store at 2:55PM unharmed. The resident was taken to the hospital for observation and returned to the facility on .

During observations of Resident#2 between the hours of 10AM and 1:00PM, the resident was alert and oriented. She answered questions with yes and no, but showed signs of no understanding the question. The resident was observed in the common with staff.

During a follow interview with the Administrator on , she stated the resident was admitted to the facility on a temporary basis and she would return with her family once there house was completed. The residents is independent, however since her stay her level of supervision has increased. Since the

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elopement the resident receives more 1 on 1 supervision and every 30 minute rounding. A Bracelet has been ordered to alert staff if resident goes toward the exit gate. Due to this increased level supervision and the elopement, the POA has been given a 45 day notice due to the resident needing a increased level of supervision.

During an interview with the Administrator on at approximately 2:50PM, she acknowledged the findings and provided no additional documentation for review.

Class III

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on interview and record review, the facility failed to register all employees with the Agency for Health Care Administration (AHCA) background screening clearinghouse within 10 business days of hire, for 2 of 2 sampled Staff (Staff F, Staff G).

The Findings Included:

On ay 10:10AM a review of the facilities current staffing schedule was compared with the AHCA background screening clearinghouse roster. The comparison revealed the facility failed to register the following sampled staff:

Staff F Hire Date:
Staff G Hire Date:

During an interview with the Administrator on , she acknowledged the findings.

Unclassified