STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969052	**05/29/2018**
NAME OF PROVIDER OR SUPPLIER **DISCOVERY VILLAGE AT PALM BEACH GARDENS**	STREET ADDRESS, CITY, STATE, ZIP CODE **100 DISCOVERY WAY** **PALM BEACH GARDENS, FL 33418**	

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

0000 - Initial Comments

An unannounced licensure complaint survey, CCR#2018003755, was conducted on and concluded on at Discovery Village At Palm Beach Gardens, License #12883 . The facility had deficiencies at the time of the investigation.

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

Based on interviews and record review, it was determined that the facility failed to demonstrate their grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 58A-5.0182, F.A.C. was implemented, for 1 out of 3 sampled residents (Resident #1).

The findings included:

Review of the facility's Grievance Procedure revealed that the "problem or grievances shall be documented on a complaint log as well as follow up actions taken by the provider to resolve such problems. The provider shall ascertain feedback from the resident in order to determine if interventions made for resolution are satisfactory to the resident(s) who made the complaint". The policy and procedure also states, "The residents' monthly meeting is used as a medium for residents to express themselves in terms of complaints or grievances related to any issue that affects them in their living environment. The provider or the staff who has the responsibility of initiating the meeting , documents grievances and complaints voiced by the residents as well as interventions done by appropriate staff to each complaint for satisfatory solution. The problem or grievances shall be also documented on a complaint log as well as follow-up actions...".

During interview with Staff C on at 12:30 PM, she stated that she had conducted medication training for staff as a result of a concern voiced during a visit from the Ombudsman's office on . Review of the monthly residents' meeting revealed a grievance by an unidentified resident indicating "medications are not always delivered on time". Additionally, a grievance dated on a Resident Complaint Form from the representative for Resident #1 documents "medications are not being given" with no response or resolution documented to address the alleged medication errors.

During interview conducted with the Administrator, on at 1:20 PM, the lack of documentation of the medication related grievances and response from the facility was discussed. The facility provided no additional information for review at this time.

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DISCOVERY VILLAGE AT PALM BEACH GARDENS	**100 DISCOVERY WAY PALM BEACH GARDENS, FL 33418**

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

Class III

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

Based on record review and interviews, the facility failed to ensure medication was provided as ordered, as evidenced by errors and omissions in documentation on the Medication Observation Records (MORs) for 2 out of 3 sampled residents (Residents #1 and #2).

The findings included:

1. During review of the , and 2018 MORs for Resident #1, the following errors and omissions were identified:

a. , 500mg, ordered to be given every 6 hours for 10 days (scheduled for 6:00 AM, 12:00 PM, 6:00 PM and 12:00 AM)
1. The first dose was initialed by staff as given at 12:00 PM on .
2. The dose to be given on at 12:00 PM was blank.
3. The doses to be given on and at 12:00 AM were blank.
4. The doses to be given from through at 12:00 AM were blank.
5. The dose to be given on at 6:00 AM was blank.
6. The medication with a start date of should have been finished 10 days later, on . However, there were ongoing doses documented as given on , and at 6:00 AM, 12:00 PM and 6:00 PM.

b. On at 4:00 PM, doses of and Dilitiazem were not documented as given.

c. On at 8:00 AM, doses of , , , , , and , were not documented as given.

d. On at 4:00 PM, , 25mg (1/2 tablet, 12.5mg), was documented as given twice.

e. On at 8:00 AM, , 25mg (1/2 tablet, 12.5mg), was documented as given twice.

f. On at 8:00 PM, was not documented as given.

2. During review of the , 2018 MORs for Resident #2, the following errors and omissions were identified:

a. 500mg, ordered to be given 3 times daily for 3 days (scheduled for 6:00 AM, 8:00 AM, 12:00 PM, 4:00 PM and 10:00 PM)
1. The first dose was initialed by staff as given at 10:00 PM on .

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969052	**05/29/2018**
NAME OF PROVIDER OR SUPPLIER **DISCOVERY VILLAGE AT PALM BEACH GARDENS**	STREET ADDRESS, CITY, STATE, ZIP CODE **100 DISCOVERY WAY** **PALM BEACH GARDENS, FL 33418**	

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

2. On , the medication was initialed as given 4 times at 6:00 AM, 12:00 PM, 4:00 PM and 10:00 PM.

3. On , the medication was initialed as given 5 times at 6:00 AM, 8:00 AM, 12:00 PM, 4:00 PM and 10:00 PM.

4. The ordered medication to be given was a total of 9 pills (3 times a day for 3 days). However, there were 3 additional doses initialed as given, a total of 12 doses documented as provided.

b. 125 MCG, ordered to be given once daily (scheduled for 1:30 PM), was not documented as given (blank) on and .

During interview with Staff C and the Administrator on at 1:00 PM, they acknowledged that the facility does not keep track of the amount of pills that arrive to the facility or pills that are sent out from the facility to the pharmacy for repackaging. During a telephonic interview with the pharmacy representative at this time, he stated that the pharmacy does not track the amount of pills that are received or repackaged into bubble packs for the facility's use. Therefore, it could not be determined whether the errors in documentation on the MORs noted above were due to inaccuracies or missed medications. The facility provided no additional information for review at this time.

Class III