STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969234	05/24/2018
NAME OF PROVIDER OR SUPPLIER **HARBORCHASE OF PALM BEACH GARDENS**	STREET ADDRESS, CITY, STATE, ZIP CODE **3000 CENTRAL GARDENS CIR** **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# 2018003775 and CCR# 2018004197, was conducted on and at Harborchase of Palm Beach Gardens, License # 13037. 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 observation and interview it was determined the facility failed to post in full view in a common area accessible to all residents the numbers for lodging complaints against a facility or facility staff and these phone numbers must be posted in close proximity to a telephone accessible by residents of the Memory Care Unit.

Based on observation and interview it was determined the facility failed to provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. on each floor of the facility.

Based on interview and record review it was determined the facility failed to have a written grievance procedure for receiving and
responding to resident complaints in accordance with Section 429.28, F.S., and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.

The findings include:

1) During observational tour of the Memory Care Unit conducted with the ED (Executive Director), on beginning at approximately 9:25 AM, he was asked where the complaint telephone numbers were posted (i.e. The telephone
numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800) 962-2873). The ED showed this surveyor a closed off alcove by the elevator and 2 fire doors on the first floor of the Memory Care Unit. He acknowledged these numbers were not readily accessible in a common area and that they were not posted in close proximity to a telephone that is accessible by residents of the Memory Care Unit.

2) During observational tour of the Assisted Living Unit and Memory Care Unit conducted with the ED, on beginning at approximately 9:10 AM, he was asked if all residents of this facility had their

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own phones. He stated each apartment is wired for a phone, but not all residents have one. He was asked how the facility provides each resident with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication on each floor of the facility. He stated a staff member can take the resident to a phone. He was asked how that is unrestricted and private access. He replied that it was not.

3) During interview and record review conducted with the ED, on beginning at approximately 10:00 AM, he acknowledged there were no grievances noted on the grievance logs from - . The Grievance/Concern Report noted, "This form shall be utilized to provide written documentation of any concern expressed by a resident or resident representative and to record the follow-up action taken and results thereof."

During subsequent interview conducted with the ED, on beginning at approximately 12:45 PM, he was asked if he had any concerns reported by (or on behalf of) Resident #1, Resident #2, Resident #3, or Resident #4. He stated he has multiple emails from family members of Resident #3 expressing concerns. He was asked if any grievance forms were completed for these concerns. He replied that they were not. He also stated he has noted concerns, in his own notebook, that have been expressed by the family of Resident #4. He was asked if any grievance forms were completed for these concerns. He replied that they were not. Therefore,the facility was unable to provide document evidence of receipt and/or resolution of the concerns expressed by the residents .

Class III

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

Based on interview and record review, it was determined the facility failed to make every reasonable effort to ensure that prescriptions for residents who receive assistance with the self-administration of medications or medication administration are filled in a timely manner for 1 of 4 sampled residents (Resident #4).

The findings include:

During interview and record review conducted with the DRC (Director of Resident Care), on beginning at approximately 11:30 AM, she acknowledged Resident #4 was admitted with order for , take 1-2 tablets every 6 hours as needed for pain. She also acknowledge this resident had recently had surgery. The DRC acknowledged the was not available on and and that a facility nurse had to go to another pharmacy to get the

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filled on . . . . Therefore, Resident #4 did not receive any pain medication on . . . . . and . . . . . , after recent . . . surgery.

Review of the letter that is provided at the time of admission, to residents or their representatives, from the facility's pharmacy reflected "Please be aware that your insurance company has formulary restrictions and some medications may require an authorization from your doctor; which may take several days. We will provide you with enough medication to get you through this period as we work with your doctor to get authorization for the medication prescribed or a covered alternative."

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation and interview it was determined the facility failed to conspicuously post or have the weekly menus available to the residents of the Assisted Living Facility or the Memory Care Unit.

The findings include:

During observational tour of the facility conducted with the ED (Executive Director), on . . . . . beginning at approximately 9:10 AM, the main dining . . . Assisted Living was observed. The ED was asked where the weekly menu is posted or available to the residents in Assisted Living. He called over the Director of Hospitality. The Director of Hospitality acknowledged the weekly menu is not posted or available to the residents at the time of this observation.

During observational tour of the Memory Care Unit conducted with the ED, on . . . . . beginning at approximately 9:25 AM, he was asked where the weekly menu is posted or available to the residents in Memory Care. He asked the FSW (Food Service Worker) that was present at the time of this observation where the weekly menu was posted. She replied it is not.

During subsequent observation of the Memory Care Unit, conducted on . . . beginning at approximately 9:00 AM, there was still no weekly menu posted or available as confirmed by the RSC (Resident Services Coordinator) at the time of this observation.

Class III