STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969008	06/20/2018
NAME OF PROVIDER OR SUPPLIER **THE CABANA AT JENSEN DUNES**	STREET ADDRESS, CITY, STATE, ZIP CODE **1537 NE CEDAR ST** **JENSEN BEACH, FL 34957**	

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

0000 - Initial Comments

An unannounced relicensure survey was conducted on - at The Cabana at Jensen Dunes, License # 12879. The facility had deficiencies at the time of the visit.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and an interview, the facility failed to ensure the resident's health assessment (AHCA Form 1823) was completed within sixty (60) days prior to admission, or within thirty (30) days after admission for 1 out of 2 sampled residents (Resident #1).

The findings included:

On , the health assessment (AHCA Form 1823) dated was reviewed for Resident #1. The resident was admitted to the facility on , as noted in the resident's progress notes. The following errors were identified:

a) The assessment was dated "2017", but was conducted on . This was a documentation error.
b) The assessment was completed more that 30 days after admission.

These findings were acknowledged by the Administrator during interview on at 11:00 AM. The facility provided no additional documentation for review at this time.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, interview, and record review it was determined the facility failed to provide a medication to 1 of 1 sampled residents that were observed for medication applications (Resident #12) according to manufacturer's recommendations.

The findings include:

During observation of Staff F administering disc 13. 1 patch daily (generic for) to Resident #12, on at approximately 8:40 AM, she asked this resident if she would rather have the patch applied to her back or her arm. The resident replied, "back." This

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nurse removed the old patch, dated [redacted], from this resident's left upper back. There was approximately 6 round overlapping adhesive residue marks on this residents left upper back. Staff F applied this new patch, dated [redacted], to Resident #12's right upper back. The nurse was asked where the nurse's document the location of the placement of medication patches. She acknowledged they do not. She stated she could make a note for today in the medical record but that there was not a method to do this in the electronic MAR (Medication Administration Record) system. Staff F was asked if she was aware the package insert recommends this medication patch not be applied to the same area for 14 consecutive days (as it has the potential to cause skin irritation). She stated she was aware of this.

During subsequent interview with ED (Executive Director), conducted on [redacted] beginning at approximately 10:10 AM, she acknowledged that the electronic medical records system did not (currently) have a method to track the site of the application of a medication patch until she reviewed this concern with the nurse. This feature has since been activated. She acknowledged that there was no prior record of application sites for this medication patch for Resident #12.

Class III

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

Based on record review and interviews, the facility failed to ensure medications were refilled in a timely manner for 1 out of 5 sampled residents (Resident #1).

The findings included:

On [redacted], a print out of the [redacted] 2018 electronic Medication Observation Record (MOR) was reviewed for Resident #1. The MOR showed that the resident did not receive two (2) medications as evidenced by the staff's initials documented in parentheses as noted below:

a) Eldertonic, to be given once a day at 9:00 AM-staff initials parenthesized on [redacted].
b) [redacted] ([redacted] B1), to be given once a day at 9:00 AM-staff initials parenthesized on [redacted].

During interview with the Administrator on [redacted] at 11:00 AM, she confirmed that the parenthesized initials on these dates indicated that the resident's medication had not been administered. She acknowledged that staff were to request medication refills when the resident had an eight (8) day supply remaining. Upon further review, the Administrator determined that staff had requested these medications to be filled on [redacted] at 9:36 AM. Review of the medication label for Eldertonic showed

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that the most recent prescription was started on . There was no system in place to identify what dates the medication refills were requested prior to the last request on . It could not be determined if the facility staff had requested these medication refills timely. The facility provided no additional documentation for review at this time.

Class III