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	AL11943102	**07/11/2018**
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SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

Unannounced licensure Complaint investigations, CCR #2018007696, CCR #2018004272, CCR #2018004383 and CCR #2018004493, were conducted on , 2018 through , 2018 and , 2018, concluding on , 2018 at Savannah Court Of The Palm Beaches, License #8367. The facility had deficiencies identified at the time of the investigations.

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

Based on record review and interview, the facility failed to ensure all residents' Agency for Health Care Administration Health Assessments (AHCA Form 1823) were accurate and reflective of the residents care needs for 4 of 9 sampled residents (Residents #6, #21, #12 and #13).

The Findings Included:

1. Review of Resident #6's AHCA form 1823 revealed the wrong facility name on the front of the form with no facility address or phone number. Further observations of the form revealed that Resident #6 needs medication "administration". During an interview with Staff A on at 1:00 PM, revealed that she gives Resident #6 her medications daily when she is on duty, and that the resident requires "assistance" with self-administration of medications.

During an interview with the Resident Care Director at 1:10 PM on , the findings were discussed and acknowledged, no further documentation was provided for review.

2. Review of the AHCA 1823 form dated for Resident #21 revealed a diagnosis of , , , high , , , , physical or sensory uses rolling walker, or behavioral status: alert and oriented times three, nursing/treatment/ , service requirements: medications, special precautions: risk for ,

Review of the section that asks "does this individual need help taking his/her medications needs?" it is checked of "Yes" and it is further checked off for medication administration.

During an interview with the Resident #21 on and Staff A, it was revealed that Resident #21 receives medications by unlicensed staff, and that the resident requires assistance with self-administration of medications. Additional review revealed that the 1823 form dated , has no signature for the guardian or recipient on page 5.

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3. On at approximately 9:55 AM a medication pass was observed with Staff G and Resident #12 who received: , 2.5mg Tablet, , Chew 81mg, Tablet 25mg, 75mg. and Tablet 325mg. At this time Resident #12 stated he was and receives from the nurse before breakfast. He also stated he was not sure if he received his . At this time, Staff G stated the nurses administer the . The surveyor confirmed the was given.

On at 11:00 AM, a record review was completed for Resident #12 and revealed an AHCA Form 1823 dated that documents a medical history of Overactive , , Adverse Effect of Unspecified , . The AHCA Form 1823 documents the resident as using a walker due to an unsteady gait and is alert and oriented. The resident requires nursing services to monitoring his sugar. Further review of the AHCA Form 1823 revealed no documentation of Resident #12 being an Dependent and there is no diet order on file. On page 2 Section D that documents if the residents care needs can be met at an Assisted Living Facility, is left blank. Page 4 Section B documents the resident needs "administration" of his medications. At 9:55AM, Staff G (who is a Med Tech) was observed assisting Resident #12 with self-administration of medications.

4. On at 10:00AM, a record review was completed on Resident #13 and revealed a AHCA Form 1823 dated and documented a medical history of , , History of , , , , , , , Incontinence, Functional , , and . Resident has and is alert to self with some . The AHCA Form also documents resident has a and nursing service to assist with maintenance. Further review of the AHCA Form 1823 revealed no height or weight documented, page 4 Section B documents resident requires "administration" of medication, and page 5 Section D which addresses services offered or arranged is left blank, and the form is not signed.

On at 1:00PM, the Administrator and Resident Care Director acknowledged the findings and provided no additional documentation for review.

Class III

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

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Based on record review, the facility failed to ensure a new health assessment (AHCA Form 1823) was completed upon a significant change for 2 out of 2 sampled residents (Residents #2 and #5).

The findings included:

1. Review of AHCA Form 1823 for Resident #2 dated . . . . . revealed no behaviors and no special precautions. The assessment notes the resident is not an elopement risk.

On , an Adverse Incident report documents that the resident eloped from the facility , and was placed in the secured unit. Review of the resident's record shows no subsequent health assessment completed for this resident's significant change (new behavior). The current assessment does not accurately represent the resident's status as "at risk for elopement".

2. Review of AHCA Form 1823 for Resident #5 dated . . . . . revealed no behaviors and no special precautions. The assessment notes the resident is not an elopement risk.

On , an Adverse Incident report documents that the resident was found wandering within the facility, and was placed in the secured unit as a result. Review of the resident's record shows no subsequent health assessment completed for this resident's significant change (new behavior). The current assessment does not accurately represent the resident's status as "at risk for elopement".

These findings were mentioned during interview with the Administrator on . . . . . at 2:30 PM.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review, interviews and observations, the facility failed to ensure adequate supervision was provided during the 3:00 PM to 11:00 PM shift in the secured unit, affecting 21 out of 21 possible residents (Resident #3, specifically identified). It was also determined that the facility does not have appropriate supervision in the unsecured unit.

The findings included:

On . . . . . at 10:00 AM, Staff L stated that the secured unit has two resident aides and a nurse on staff during all shifts. During a confidential interview, it was revealed that the nurse assigned to the secured unit is the nurse for the entire facility, who floats in and out of the secured unit for medication

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administration. The secured unit has 21 residents currently. The facility's current census is 73.

During the 7:00 AM to 3:00 PM shift on and , observation of resident supervision revealed Staff L (LPN) and an activities representative assisting the two (2) aides assigned to 21 residents in the secured unit. The aides were observed completing multiple assignments, including food service, set up and clean up of the dining kitchen area before and after meals, four (4) assigned resident showers, toileting of ten (10) residents, and assistance with transfers and ambulation (wheelchairs and walkers) for ten (10) residents, as well as supervision of residents who ambulate independently. These assignments remained the same for the 3:00 PM to 11:00 PM shift. However, the afternoon shift did not have activities staff providing ongoing assistance with supervision during activities, or a nurse assisting with supervision for the entire shift. During a confidential interview, it was revealed that there are two (2) aides alone during the afternoon shift with minimal assistance provided to supervise residents. Additionally, the majority of the residents in the secured unit have , and wandering that escalates in the evenings due to " associated with diagnoses of 's .

On (is the date of the incident noted in the narrative) at 5:30 PM, an Adverse Incident report indicates Resident #3 was found in another resident's an injury to her face. Resident #3's health assessment (AHCA Form 1823) dated notes that the resident requires "assistance" with ambulation and transfers. The resident was not assisted with ambulation into the male resident's . The report indicates that the resident was thought to have been hit by the male resident. The report shows the facility's corrective action or proactive action is to prevent Resident #3 from entering other resident's . There was no evidence of a review of the staffing or level of supervision being provided during the 3:00 PM to 11:00 PM shift following the incident.

On at 4:10 PM, an Adverse Incident report indicates Resident #4 eloped from the secured unit through the back door. The report shows the facility's corrective action or proactive action is to extend a fence, place a "closed" sign on the door, and install a louder alarm. There was no evidence of a review of the staffing or level of supervision being provided during the 3:00 PM to 11:00 PM shift following the incident.

Based on the aforementioned findings, the facility does not provide adequate staffing to residents (currently 21) in the secured unit. These findings were brought to the Administrator's attention on at 2:30 PM.

During confidential staff interviews conducted on and , it was revealed that the facility needs additional staff during the day and night shift. Staff revealed that a majority of the time, the facility

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has two persons per floor and at night only 1 person. The staff is responsible for multiple tasks, including medication. Therefore, making it very difficult to provide supervision and care and services as appropriate for each resident. It was also revealed that during the weekend there is also insufficient staffing. Staff members are calling out ill and the facility is not sending a replacement.

Class III

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

Based on record review and interviews, the facility failed to ensure medications were provided by Licensed Practical Nurses (LPNs) without error, affecting 21 out of 21 sampled residents in the secured unit (Residents #10 and #15, specifically identified).

The findings included:

1. On . . . . at 9:00 AM, Staff L (LPN/Licensed Practical Nurse) stated that he had finished giving all of the morning medications to residents in the secured unit. Review of the 2018 MOR (Medication Observation Record) for Resident #10 showed that none of his morning medications were initialed as given. At this time, Staff L stated that he had not given any morning medications because the previous shift's LPN had completed this taks prior to his arrival. Attempts to contact Staff K (LPN), who worked the previous shift and had given morning medications to residents, were unsuccessful. This surveyor left a voicemail for Staff K at 12:00 PM, but did not receive a call back on this date (. . . .).

During interview with Resident #10 at 10:00 AM and 12:15 PM on . . . . , he stated both times that he had not received any of his morning medications, and that his "eye drops were the most important". Review of the resident's MOR showed he receives eye drops three times a day, one of them to be provided at 9:00 AM.

On . . . at 10:00 AM, the Resident Care Director stated that Staff K had responded to their calls and stated that she had given Resident #10 his morning medication. She subsequently documented on the resident's MOR that she did provide the morning medications on . . . . Staff K was contacted at 11:00 AM on . . . . and stated she had given Resident #10 his morning medication, but had forgotten to document on the MOR at that time. The RCD stated that Resident #10 "has " and would not know if he received medication or not.

At 10:30 AM on . . . , the RCD and this surveyor interviewed Resident #10. When asked if he

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received his medication today, he stated "yes, I did. But I did not receive it yesterday until after lunch". When asked who gave him his medications, he described Staff L as giving him his medication on "after lunch, late" and again on time in the morning on .

There is no system in place to confirm or negate a medication error after the fact since the facility does not utilize a system put in place to ensure medication errors can be identified.

2. Review of the 2018 MORs for all resident in the secured unit (approximately 21 residents) revealed none of their morning medications were documented as given on at 9:00 AM. During interview with the RCD at 10:00 AM on , she was unable to explain why the medications were not documented as given as she was unaware of these omissions. On at 10:15 AM, the RCD explained that an LPN who worked the day shift on (Staff M) had admitted to not giving morning medications to all residents in the secured unit on . There was no system in place to ensure missed documentation of medication was immediately identified and errors revealed once they occurred. These medication errors that occurred on were not identified until when this surveyor reviewed the MORs.

3. Review of Resident #15's 2018 MOR revealed , 250 mg, to be given once daily, was documented in two separate rows on the MOR. The medication was duplicated on the MOR with two different times listed for the medication to be given, once at 8:00 AM and again at 9:00 AM. During review of the medications available, it was realized that the resident had a prescription bottle with 20 pills remaining, and a pack with 26 pills remaining. However, the RCD was unable to determine if the resident had actually received two pills each day, or one pill a day. There was no system in place to confirm the amount of pills that were distributed to the resident. The MOR documented that the resident received this medication twice a day on , and . There was no documentation to show that the staff distributing this medication were aware of the error.

These Administrator was notifed of these medication errors on at 2:30 PM.

Class III

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

Based on observation and interview, the facility failed to ensure that all resident medications were listed on the Medication Observation Record (MOR) for 1 of 14 sample residents (Resident# 11).

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The Findings Included:

1) On at 9:40 AM a medication audit was completed for Resident #11 and revealed the resident has a medication bingo card in the drawer for one Tablet 50mg, to be given nightly at hour of sleep. At the time of observation, the bingo card was missing one pill from the 30th date slot. At this time a review of Resident #11's 2018 MOR revealed 50mg was not listed as given from through . At this time the Medication Monitoring / Control Record was reviewed and revealed Resident #11 received a dose of 50mg on the following dates: , , , , , , and . None of the medication given on those dates were documented on the MOR. At this time a review of the MORs for the 3 previous months were reveiwed and revealed the 50mg was recorded on the previous MOR's.

During an interview with Staff G on at 10:00 AM, it was brought to her attention, and she stated that the omissions have been reported to nursing staff but the entries had not been added to the MOR. During an interview with the Director of Nursing, she stated she recalls the MOR issue, but was unable to given any additional details.

During an interview with the Administrator and the Director of Nursing on at 1:30 PM, they acknowledged the findings.

2) Random review of the MORs revealed staff signatures are not identifiable. During review the identity of random staff were questioned to follow up on medication concerns. However, the DON and the Wellness Director were unable to identify the staff members. The facility did not have the signature legend (located on the top of the MORs) completed to identify the name of the staff and their signatures.

Class III

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

Based on observation, record review and an interview, the facility failed to ensure medications were refilled timely for 3 out of 7 sampled residents (Residents #6, #10 and #15); and, failed to ensure "as needed (PRN)" medication for 3 out of 7 sampled residents (Residents #1, #5 and #10), had specific instructions for use, including the circumstances under which it would be appropriate for the resident to request the medication and any limitations.

The findings included:

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1. On at 10:00 AM, the medication supply for Resident #10 was reconciled with the resident's 2018 MOR (Medication Observation Record). The MOR showed that the resident was to receive "PRN" or "as needed". The medication was not available at this time.

After review of the history of orders for this medication, the Resident Care Director/LPN stated that the medication was discontinued on , but a staff nurse had added the medication to the monthly orders for the resident's health care provider (HCP) to sign. When the HCP signed the orders in 2017, the medication was put back on the MOR as a currently precribed medication. The facility had not identified this since , 2018, and had therefore not ordered a new supply of the medication. During further interview, it was revealed that the RCD did not routinely reconcile the residents' medications to ensure their availability and accuracy of the MORs. She stated during interview at 11:45 AM on that the pharmacy reconciles the medications for all residents, even those that they don't provide medications for. However, there is no documentation of these reconciliations, and no evidence to show any of the residents' medications are reconciled and accounted for. Additionally, the pack system that the facility was to use to ensure medications, if missed, could be identified at a later date, was not utilized by the facility. The packs that have numbers next to each dose to be given were not followed in any chronological order to ensure medication errors could be identified.

2. On at 10:00 AM, the medication supply for Resident #15 was reconciled with the resident's 2018 MOR (Medication Observation Record). The MOR showed that the resident was to receive inhaler three times daily. The MOR listed the times to be given at 8:00 AM, 2:00 PM and 8:00 PM. The medication was not available at this time, and the following documentation had been completed:

a. On , staff initialed all three times on this date that the resident did not receive the medication by circling their initials on the MOR.
b. On , Staff K (LPN/Licensed Practical Nurse) initialed that the resident received this medication at 8:00 AM. At 2:00 PM and 8:00 PM, staff initialed that the resident did not receive the medication.
c. On , Staff K (LPN/Licensed Practical Nurse) initialed that the resident received this medication at 8:00 AM.

There were two entries noted on the back of the MOR on at 8:00 AM and 2:00 PM to explain that the resident's medication was not given and that someone was notified. During interview with the Resident Care Director/LPN at this time, she was unable to explain why the medication had not been

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obtained, and why it was being intitialed as given at times when it was not available.

3. On at 10:00 AM, the 2018 MOR for Resident #1 was reviewed and listed " Concentrate 2MG/ML, one half ML by mouth every 6 hours as needed". There were no instructions listed for what reason this resident was to receive this medication.

4. On at 10:00 AM, the 2018 MOR for Resident #5 was reviewed and listed " , .5mg, every 6 hours as needed". There were no instructions listed for what reason this resident was to receive this medication.

5. On at 10:00 AM, the 2018 MOR for Resident #10 was reviewed and listed " 25mg, as needed". There were no instructions listed for what reason this resident was to receive this medication.

6. When auditing the Medication Cart on at 1:45 PM with Unlicensed Staff (Staff A) three of Resident #6's PRN (As needed) medications were missing from the Medication Cart: and Tablets, 7.5 mg tablets, and adult-liquid.

During an interview with Staff A on at 2:00 PM regarding the missing medications it was stated that this was reported to the nurse, and that refills were never ordered.

During an interview with the Resident Care Director (RCD) on at 2:20 PM the findings were discussed and acknowledged, and no further documentation was provided during this time.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interviews, the facility failed to ensure a clean and decent living environment, free of water leaks and mildew like odor; and, failed to ensure that all existing structural systems are maintained in good working order.

The Findings Included:

1) During the observational tour on between the hours of 9:30AM - 1:00PM, on the second floor there were several areas where evidence of water leaks were observed. The facility had a

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moderate mildew life odor on the second floor. The 1st floor was observed and there was a stronger odor of mildew. Further observation at approximately 10:10AM revealed in the carpet in the saturated with water in front of the air conditioner and throughout the . The a moisture in the air and had a musky odor. The resident was observed sitting in a chair with his feet on the soaked carpet. The resident was aware the carpet was wet, but spoke primarily Spanish and did not understand questions. On a maintenance slip was reviewed that revealed it was reported that # 's carpet was "still wet".

The Maintenance Log also revealed several additional reports of leaks: on an order was put in that reported a ceiling leak in the Wellness Center; on a report was filed for regarding water in the from the ceiling; and, on # reported water in the . Further observation was completed and revealed several areas of the walls in the hallways on first and second floors were peeling and showed evidence of water damage to the wall and ceiling. There was observation of air conditioning vents with rust and dark substances on the first and second floor. On the second floor across from the Nurse Director office there is a unlocked , being used as a storage . The a large vent that is not cover with a screen and allows direct exposure from the outside. The boxes of documents stored. Several of the boxes have water stains and the evidence of dried water on the floor.

On at 11:00AM, a review of the facility Grievance Log was completed and revealed on a letter was submitted documenting # 's carpet had been soaked from a recent rain storm. The letter also mentioned the were soaked during the hurricane last year. The letter was requesting the problem be fixed prior to the next storm.

On at 1:00PM # was entered. There was evidence of dried water under the air conditioner and the base boards were peeled away from the wall. At this time an interview was conducted with the resident of the (Resident #14). She stated the carpet gets very wet when it rains an it has been reported to the office. She also stated that when it leaks the maintenance department comes in and dries up the carpet, but the leak has not been repaired.

On at approximately 10:30AM, during an interview with Maintenance personnel, he stated he has only worked at the facility for 3 weeks and he was aware of the leaking in and that they were trying to stay on top of the problem.

2) While conducting a tour of the facility on and throughout the survey, the following was observed:

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a) Small roaches were observed crawling on the table in the private dining various occasions where the facility stationed the surveyors to work on day 1 and day 2 of the survey.

b) The carpet in the dining observed to have a mold like odor, and was observed to have stains and dirt embedded that would not come out with the carpet being cleaned. Further observations revealed stains of old food on the bottom of the dining that were present both days of the survey.

c) The for men and women used for residents and visitors in the front of the facility was observed out of order both days. Observations of the staff which visitors and residents were directed to use was also out of order. One of two toilets in the staff observed stopped, unable to flush and overflowing posing a safety hazard for Residents, Visitors, and staff.

d) revealed an odor of and water leak inside the was observed leaking from a pipe behinf the toilet. Futher observations revealed brown stains on the carpet in the ceiling tiles missing from the ceiling in inside the common area.

3) Observations of the kitchen on day 2 at 9:05 AM with the Food Service Director, revealed the following.

a) The floor was observed sticky with the grates full of trash. The freezer was also encrusted with trash and dirt that resembled mildew along the door and the door handle. The sign on the freezer was also observed dirty.

b) Observations of the floor revealed black dirt encrustation throughout the brown tiled floors in the corners along the walls of the kitchen. Observations of the kitchen's storage more black dirt encrusted on the floor along with food crumbs underneath the shelves. The container that holds the scooper for the flour and the rice was observed with old crusted flour on it and dirt and old crusted floor observed at the bottom of the scooper container that has built up.

c) Clean cooking utensils were observed placed onto the wall that was dirty in the kitchen, dirty knives were also observed packed in a knife rack hung onto a dirty wall. When pulled out of the rack the knives were observed stained and bent on the part of the knife that cuts food. Some of the knives were observed with parts of the missing metal.

d) Observations on the inside of the freezer revealed various colored spots that resembled a mold like substance on the flaps going into the freezer. Further observation of the flaps revealed condensation

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and dirt build up on each flap. Observations of the vegetables stored in the freezer revealed potatoes that were rotten and that had fuzzy particles growing on them. Observations of the metal shelves that had the meats stored on them revealed dirt along each shelf on the rack, and one of the shelves were observed broken and hanging off the rack.

e) Observations of the area leading into the entry way of the kitchen revealed rodent droppings in the area next to the ice machine additional to a dried white liquid material observed on the floor. Observations of the wooden stands used to set resident trays were observed with old food stuck between the crevices. Observations of the area underneath the sink revealed a dirty white bucket filled with gnats crawling around the bucket and inside the bucket. When the food service director removed the bucket from under the sink gnats began flying out and thick dirty brown liquid was observed inside.

During an Interview with the Food Service Director at 9:42 AM on it was stated that he was unsure what was in the bucket or how long it had been sitting there.

During an interview with the Administrator on at 9:50 AM the physical plant findings found in the kitchen were discussed and acknowledged. No further information was provided during this time.

4) On at 12:00 PM, a tour of the secured unit on the first floor was conducted. There were multiple areas observed with water damage as noted below:

a. -strong odor of mildew and visible water damage to walls near air conditioner, painted over

b. -closet with strong odor of mildew, painted over

c. -strong odor of mildew throughout the Dining -bowing baseboards damaged by water; wallpaper from wall due to water damage; and, black spots on wall in closet near floor.

During a confidential interview, it was revealed that the facility has not repaired water leaks, and consistently paints over mildew and water damage in residents' closets and walls.

These findings were reviewed with the Administrator and Corporate representative on at 2:30 PM. The facility provided no additional information for review at this time.

Class III