STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953528	10/25/2018
NAME OF PROVIDER OR SUPPLIER **WYNDHAM HOUSE**	STREET ADDRESS, CITY, STATE, ZIP CODE **417 WESTWOOD ROAD** **WEST PALM BEACH, FL 33401**	

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

0000 - Initial Comments

An unannounced licensure complaint survey, CCR #2018012797, was conducted on . . . . . at Wyndham House, License #63. The facility had deficiencies identified at the time of the survey.

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

Based on record review and interview, the facility failed to ensure that all residents were supervised, and assessed for . risk prevention, for 3 of 3 sample residents(Resident#1, Resident#2 & Resident #3).

The Findings Included:

a) On . . . . . at approximately 1:00PM record review was completed for Resident#1 and revealed the Agency for Health Care Administration Health Assessment (AHCA Form 1823) documented the resident requires assistance or supervision with all Activities of Daily Living (ADL's). She can ambulate without an assistive device however, she needs contact guard or someone to hold arm. The AHCA Form 1823 also documented the resident requires supervision with toileting and transferring. The AHCA Form 1823 does not document the resident as a . risk. Further review of the resident's progress notes revealed on . . . . . , the resident . in dining . . . No incident report was completed and it was documented in the resident observation notes. Review of an incident report was completed documenting the resident . on . . . . . and was not documented in the resident progress notes. At no time was the resident assessed for . risk and no follow-up prevention efforts were made. At this time, the facility does not have a . . policy in place.

b) On . . . . . at approximately 1:30PM, a record review was completed for Resident#2 due to the facility submitting an Adverse Incident Report due to a . . On . . Resident . and was transferred to the hospital. A Preliminary Adverse Incident was submitted on . . . . . and the 15 day full, report was submitted on . . . . . . The report was closed on . . . . . . Further review of the resident record revealed the resident was on Hospice care and the AHCA Form 1823 documented the resident required " . . . . . all ADL's and with Ambulation", due to unsteady gait. The AHCA Form 1823 also documents the resident requires "close monitoring for possible "high risk" for . . . . During an interview with the Administrator at this time, he stated the resident was allowed to ambulate with walker throughout the facility with no assistance. The Administrator stated he did not review the AHCA Form 1823 and therefore was not aware of the resident's needs for supervision and assistance with ambulating and transfer.

c) On . . . . . at approximately 2:00PM a incident was reviewed and dated . . . . . . The incident

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report documented Resident#3 was identified as missing from the facility at 8:14 PM by staff. The Administrator, police, family and physician were notified. The resident was returned to the facility by law enforcement and stated she was located in the area of Palm Beach Lakes Boulevard (8 Miles away from the facility). The resident's return time was not documented and no law enfoldment report was obtained (time not documented). The exact time the resident left the facility is documented. There was no Adverse Incident reported to the agency. During an interview with the Administrator at this time, he stated he reviewed the facility cameras and determined the resident left the facility at 5:15PM through the front door. When investigated the staff stated the last time they saw the resident was at dinner time (5:00PM). The facility had an alarm on the front entrance door, but no one responded to the alarm. Further review revealed the facility has a Elopement Policy, however the policy or facility Elopement documentation was used to record events. The residents AHCA Form 1823 was not updated to identify Elopement Risk.

During an interview with the Administrator on . . . . . at approximately 3:00PM, the Administrator acknowledged the findings.

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(l)

Based on record review and interview, the facility failed to ensure that all staff followed the appropriate Elopement Protocol and Standard, for 23 of 23 residents.

The Findings Included:

On at approximately 2:00PM a incident was reviewed and dated . The incident report documented Resident#3 was identified as missing from the facility at 8:14 PM by staff. The Administrator, police, family and physician were notified. The resident was returned to the facility by law enforcement and stated she was located in the area of Palm Beach Lakes Boulevard (8 Miles away from the facility). The residents return time was not documented and no law enforcement report was obtained (time not documented). The exact time the resident left the facility is documented. There was no Adverse Incident reported to the agency. During an interview with the Administrator at this time, he stated he reviewed the facility cameras and determined the resident left the facility at 5:15PM through the front door. During an interview with staff , it was revealed the last time they saw the resident was at dinner time (5:00PM). The facility had an alarm on the front entrance door, but no one responded to the alarm. Further review revealed the facility has a Elopement Policy, however the policy or facility Elopement documentation was not used to record events of the elopement. An observation of the

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resident during the survey revealed the resident does not have any identification on her person which contains the resident name and facility name. Further review revealed no photo of the resident in the resident's file after the elopement.

A review of the facility Elopement Drills revealed, the facility last completed the required facility Elopement Drills in 2016. The facility had no Elopement Drills documented for 2017 and 2018.

During an interview with the Administrator on [redacted] at approximately 3:00PM, he acknowledged the findings and provided no additional documentation for review.

Class III

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

Based on record review and interview, the facility failed to ensure that all physician orders were transcribed and administered as directed, for 2 of 2 sampled residents (Resident#1 and Resident#4).

The Findings Included:

a) On [redacted] at approximately 1:30PM, review of the Medication Observation Record (MOR) and physician order was completed for Resident#1. It revealed that from the time Resident#1 was admitted to the facility on [redacted], she has always received [redacted] 50mg tablets twice a day for mood. Review of the MOR for [redacted] and [redacted], 2018 revealed a hand written order transcribed to the MOR indicating [redacted] 50mg , take 1 tablet twice a day. A review of the [redacted] 2018 MOR revealed the [redacted] was transcribed to the MOR's as to be given once a day. However, the MOR was signed consistently and documented the [redacted] was given twice a day as prescribed by the physician for [redacted] 2018. Further record review revealed there was no physician order that changed the [redacted] to once a day. During an interview with the Med Tech, at this time, revealed she transcribed the order incorrectly, but ensured the resident received her [redacted] twice a day as prescribed.

b) Further review of Resident#4's MOR revealed a hand written order was written on the MOR for [redacted] 0.3% eye drops in both eyes four times a day for four days to start [redacted] and due to stop [redacted]. The physician order was reviewed and verified the medication was for four days. The MOR documented the resident was currently receiving the eye drops as of today [redacted], and two doses (8AM and 12PM) had been given. At this time, the med tech and the Administrator had no reason as to why the eye drops were still being administered. The facility had no documentation indicating the

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physician had extended the order.

During an interview with the Administrator and Med Tech, they acknowledged the findings.

Class III

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

Based on record review and interview, the facility failed to submit a 1 Day preliminary and 15 Day full report to the Agency for Health Care Administration(AHCA), for 1 of 4 sampled residents (Resident#3).

The Findings Included:

On . . . . . at approximately 2:00PM, an incident was reviewed and dated . . . . . . The incident report documented Resident#3 was identified as missing from the facility at 8:14 PM by staff. The Administrator, police, family and physician were notified. The resident was returned to the facility by law enforcement and stated she was located in the area of Palm Beach Lakes Boulevard (8 Miles away from the facility). During an interview with the Administrator at this time, he stated he reviewed the facility cameras and determined the resident left the facility at 5:15PM through the front door. When investigated,the staff stated the last time they saw the resident was at dinner time (5:00PM). The facility had an alarm on the front entrance door, but no one responded to the alarm. At this time, it was determined the elopement was a result of lack of supervision by the facility which warranted a Adverse Incident be submitted. During an interview with the Administrator, at this time, it was revealed the facility had not submitted a Adverse Incident to AHCA.

On . . . . . at approximately 3:15PM with the Administrator, he acknowledged the findings and provided no additional documentation for review.

Class III