STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910337	**12/27/2018**
NAME OF PROVIDER OR SUPPLIER **INDIGO PALMS AT THE MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **595 WILLIAMSON BLVD.** **DAYTONA BEACH, FL 32114**	

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

0000 - Initial Comments

On [redacted] an abbreviated biennial relicensure survey was conducted at Indigo Palms at the Manor. Deficient practice was identified during the survey.

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

Based on a review of facility records, and interview with staff, the facility failed to ensure all of its administrators participated in elopement drills for 1 of 1 years sampled.

The findings include:

Review of elopement drills found they were being conducted monthly, with all staff in attendance except the Administrator. Photographic evidence was obtained.

An interview was conducted with the Administrator at 1:40 pm on [redacted]. He confirmed he was not participating in elopement response drills on a semi-annual basis, as required. He acknowledged the requirement for his participation in the drills.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on a review of personnel files and interview with staff, the facility failed to ensure evidence of a negative ( ) examination was documented on an annual basis for 1 of 4 sampled employees whose records were reviewed (the Administrator).

The findings include:

A personnel file review for the Administrator found he had a screening test on [redacted]. The results of the test were not documented by the examining practitioner. Neither the "positive" or the "negative"

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result was circled or underlined.

An interview was conducted with the Administrator at 12:05 pm on . He reviewed the screening form and confirmed there were no results noted. He stated he was told the result was negative.

Class III

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

Based on observation and staff and resident interviews the facility failed to ensure portable tanks were secured to prevent tipping over and creating potential safety hazard for 1 of 5 residents receiving . (Resident # 6).

The findings include:

During an interview with Resident # 6 on at 11:35am, an observation was made of portable tank standing alone without being secured in a stand or cart. She was asked if the portable tank had a holder to keep it from falling over, she said she never had one.

An interview was conducted with the LPN manager on at 12:15pm. When asked if Resident # 6's portable tank was secured in her room, she said her Durable Medical Equipment (DME) company had not provided one. She stated she wasn't aware the tanks were required to be in a holder. She said she would contact the DME company and request a holder.

Class III