STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967048	R 03/02/2019
NAME OF PROVIDER OR SUPPLIER **TYVAL ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **3526 GENEVRA AVE BOYNTON BEACH, FL 33436**	

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

0000 - Initial Comments

An unannounced licensure complaint revisit survey, CCR #2019000479, was conducted on at Tyval Assisted Living Facility, License #11128. The facility was not found to be in compliance during this visit.

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

Based on observation, interview and record review the facility failed to follow the physician's order to adequately assist with the self-administration of medications for 1 out of 6 residents (resident #1).

The findings include:

Review of resident #1's health assessment dated on indicated that the resident was diagnosed with and . Review of this health assessment indicated that the resident required to receive daily assistance with self-administration of her medications and the resident was prescribed 2.5mg medication once daily.

Review of resident #1's medication observation record (MOR) for and indicated that the resident was prescribed 2.5mg oral tablets, once daily and to hold if the resident had less than . Review of these MORs indicated that the resident did not receive the prescribed 2.5mg medication from to . Further review of the and MORs indicated that there was a handwritten direction to "hold" the prescribed 2.5mg without any other directions. Review of the resident's MOR for indicated that the resident did not receive the prescribed 2.5mg medication from to and from to .

In an interview with the administrator on at 12:25pm, she stated that she wrote on resident #1's MORs the direction to "hold" the medication because she believed that she received a physician order to hold this medication a "couple of months ago." She stated that she did not find a written physician's order to represent that the facility needed to hold the resident's medication.

Review of the resident's medical record indicated that there was no physician's order to hold or discontinue the resident's medication. Review of the resident's record indicated that the resident's was most recently monitored on and with readings of and respectively. Further review of the resident's record did not indicate that the resident received other recent monitorings by the facility staff.

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In an interview with resident #1's physician on at 12:55pm, he stated that ha was familiar with the medical care for this resident and that he did not remember to have ever ordered a hold on the resident's medication. He stated that the resident was prescribed the medication for her diagnosis. He stated that he usually discontinued a resident's medication altogether instead of ordering an indefinite hold for any medication. He stated that the resident would be at risk for not having received the medication if her was extremely high and his expectation was that the facility staff monitor the resident's daily before assisting the resident with the self-administration of this medication.

In an observation on at 1:10pm, there were two of resident #1's monthly medication cards stored inside the facility medication cart. In an observation of these medication cards at this time, it was noted that each contained several unused tablets.

In an interview with the administrator on at 1:20pm, she stated that she did not remember if and when resident #1's was ordered by the physician to be held altogether and that she usually monitored the resident's . She stated that she did not document the resident's reading she received on and she did not remember the values the resident received on .

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on record review and interview, the facility failed to maintain the personnel record for 1 out of 3 sampled staff member (staff member D) which contained this staff member's valid ( ) certification .

The findings are:

Review of staff member D's employee record, indicated that she was hired as a caregiver on or about to provide direct resident care. Further review of this employee record indicated that she did not hold a current and valid certification. Review of the facility's written weekly schedule indicated that staff member D worked in the facility continuously from Friday to Monday every week .

In an interview with the administrator on at 12:15pm, she stated that staff member D worked a

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SUMMARY STATEMENT OF DEFICIENCIES
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continuous shift from Friday afternoons to Monday mornings. She stated that she usually worked in the facility everyday from 7am to 7pm and that staff member D was solely responsible for the residents' care when she was not personally in the facility. She stated that she was not aware that staff member D was required to be trained and certified in as per rule 58A-5.0191. She stated that she was also not aware that the proof of this certification needed to be inside the employee's record.

In an interview with staff member D on at 1:15pm, she stated that she received training on or about and that she lost her card to represent a currently valid documentation of the completion of the training requirement.

Class III
Uncorrected

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on record review and interview, the facility failed to prepare a detailed emergency environmental control plan to address the event involving the loss of primary electrical power in the facility during an emergency.

The findings are:

In an interview with the administrator on at 11:10am, she stated that she did not yet develop a detailed emergency environmental control plan to supplement the facility's comprehensive emergency management plan. She stated that she did not know that she needed to submit separately the facility's emergency environmental control plan to the local emergency management agency for review and approval. She stated that she developed a single-page document titled "emergency environmental control plan" which did not contain a detailed plan to address the event of the loss of primary electrical power in the facility. She stated that she understood that this document was not a detailed emergency environmental control plan. She stated that she has not contacted the local emergency management agency to discuss the facility's emergency environmental control plan since the last Agency inspection on

Review of the facility's CEMP dated on indicated that the facility did not describe what life safety equipment and which air conditioning unit the power generator will power, the square footage to be air conditioned and how the residents will be relocated to the air conditioned space during the event of an emergency. Review of the facility's undated emergency environment control plan did not specify the acquisition of a sufficient alternate power source, safe storage and location of the fuel supply within

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the facility property in accordance with local zoning and building code, facility-specific requirements based on the residents' needs, continual safe servicing and maintenance of the equipment that provided the alternate power source and the acquisition and maintenance of a monoxide alarm. Further review of this undated emergency environment control plan indicated that it was not approved by the local emergency management agency.

Class III
Uncorrected