STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965677	03/28/2019
NAME OF PROVIDER OR SUPPLIER **VERO BEACH**	STREET ADDRESS, CITY, STATE, ZIP CODE **2425 20TH STREET VERO BEACH, FL 32960**	

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

0000 - Initial Comments

An unannounced Abbreviated Relicensure survey was conducted on through at Vero Beach, License #10057. The facility had deficiencies at the time of the survey.

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

Based on record review and interviews, the facility failed to ensure a new health assessment (AHCA Form 1823) was completed when a significant change occured, for 1 out of 2 sampled residents (Resident #12).

The findings included:

During review of Resident #12's record on , health assessments (AHCA Form 1823) dated and were located. No other health assessments were found in the resident's record at this time. Further review of the resident's record shows that the resident had a , identified on the resident's on or about .

A new health assessment with a -to- medical examination by a health care provider is required to be completed after a significant change occurs. A significant change is defined in rule 58A-5.0131, Florida Administrative Code, and includes the onset of a .

During interview with the Wellness Director on at 10:00 AM, he stated that the resident did not have a new health examination completed in when the resident encountered a significant change. The facility provided no additional information for review at this time.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on observation and interview, it was determined the facility failed to ensure the following was implemented for residents;
a) were provided assistance with obtaining access to adequate and appropriate health care consistent with established and recognized standards within the community, specifically related to staff failure to wash or sanitize when providing assistance with the self-administration of medications for 2 of 4 sampled residents (Residents #1 and #4).

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b) each resident's right to privacy was honored; specifically related to the computer screen on the medication cart being left "open" and accessible to residents' medication records and the residents' records (binder) being left accessible on top of the medication cart for 4 of 4 sampled residents (Residents #1, #2, #3, and #4).

The findings included:

1) During medication observation conducted with Staff A, on beginning at 8:55 AM, this staff member was not observed to wash or sanitize prior to providing Resident #1 with her medications.

2) During medication observation conducted with Staff A, on beginning at 9:40 AM, this staff member was not observed to wash or sanitize prior to providing Resident #4 with her medications. Resident #4 handed her pill to Staff A and Staff A took this medication with her bare unwashed and unsanitized . Resident #4 requested that Staff A cut this pill in half to make it easier for her to swallow. Staff A cut this pill in half and returned it to Resident #4 per resident request.

3) During medication observation conducted with Staff A, on beginning at 8:55 AM through 9:55 AM, this staff member left the computer screen "open" and residents' medication observation records visually accessible in the hallways outside of resident rooms for Residents #1, #2, #3, and #4. In addition, residents' records (in a binder) were left unattended and on top of the medication cart in the hallway outside of resident rooms for Residents #1, #2, #3, and #4.

During an interview with Staff A on at 10 AM, aforementioned was confirmed.

Class III

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observation, interview, and record review it was determined the facility failed to ensure unlicensed staff that provides assistance with the self-administration of medications did so in accordance with procedures described in section 429.256, F.S. and this rule, specifically related to not following medication orders for 2 of 4 sampled residents during medication observation conducted on (Resident #1 and Resident #2).

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The findings include:

During medication observations conducted on [redacted] conducted with Staff A (an unlicensed staff member providing assistance with the self-administration of medication) the following concerns were identified:

1) On [redacted] at 8:55 AM, Resident #1 was provided with [redacted] 50mg (x2 tabs = 100mg). The medication label and the Medication Observation Record for [redacted] indicated this medication is to be consumed before breakfast. At the time of this observation Staff A did not inquire as to whether Resident #1 had eaten breakfast. Staff A provided all prescribed medications to this resident and this resident took them without incident. This surveyor asked Resident #1 if she had eaten breakfast this morning. She confirmed that she had. Staff A stated she was not aware this medication needed to be taken before breakfast.

2) On [redacted] at 9:32 AM, Resident #3 was provided with [redacted] 500mg. The medication label and the Medication Observation Record for [redacted] indicated this medication is to be consumed before meals. At the time of this observation Staff A did not inquire as to whether Resident #3 had eaten breakfast. Staff A provided all prescribed medications to this resident and this resident took them without incident. This surveyor asked Resident #3 if she had eaten breakfast this morning. She confirmed that she had. Staff A stated she was not aware this medication needed to be taken before breakfast.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview it was determined the facility failed to ensure centrally stored medication (maintained in a medication cart) was maintained in a locked manner at all times.

The findings included:

During medication observation conducted with Staff A, on [redacted] beginning at approximately 9:07 AM, Resident #3's medications were placed in a small plastic medication cup and were taken into this resident's room and the door to the room was closed at this time (so the medication cart was not visible to Staff A). The following medication "cards" were left on top of the medication cart:

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1) Cranberry 450mg (to be provided 3 times daily)
2) 5mg (to be provided daily)
3) Multi- with (to be provided with breakfast daily)

In addition, the medication cart was not locked by Staff A prior to leaving this medication cart unattended. There was a male staff member or contractor working in the hallway approximately 10 from this unlocked and unattended medication cart. Upon return to this medication cart, Staff A acknowledged she had left the cart unlocked with medications on top.

Class III

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

Based on observation, interview, and record review it was determined the facility failed to promptly obtain a revised label from the pharmacy or place an "alert" label on the medication when a changed in the prescriber's directions for use has been obtained for 1 of 4 sampled residents during medication observations conducted on (Resident #2).

The findings included:

During medication observation conducted with Staff A, on at approximately 9:07 AM, Staff A provided Resident #2 with 17gm dissolved in water. The MOR (Medication Observation Record) noted this is to be provided daily. The medical label indicated it is to be provided as needed for , . The physician's order, dated , indicated change to as needed for , . Staff A could not provide an explanation as to why a new medication label or "alert" label was not placed on the since .

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on interview and record review it was determined the facility failed to ensure food/meal substitution documentation, that is noted before or when the meal is served, was maintained on file in the facility for 3 days in .

The findings included:

During interview and record review conducted with the Dining Services Director, on beginning

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at approximately 11:20 AM, he was asked for the facility's food/meal substitution records. He obtained a substitution log for review. He was asked if there had been any food/meal substitutions for . He stated there were substitutions on ; ; and . He was asked why the last substitution noted on the log was dated . He acknowledged he had not maintained this food/meal substitution record in an up-to-date manner.

Class