STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910386	04/25/2019
NAME OF PROVIDER OR SUPPLIER **COLONIAL ASSISTED LIVING AT WEST PALM BEACH FL**	STREET ADDRESS, CITY, STATE, ZIP CODE **534 DATURA STREET WEST PALM BEACH, FL 33401**	

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

0000 - Initial Comments

A biennial relicensure and complaint investigation (#2019001383) was conducted on through at Colonial ALF West Palm Beach (Lic#7617). The facility had deficiencies at the time of the survey.

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

Based on record review and an interview, it was determined that the facility failed to ensure the Medication Observation Record (MOR) was up-to-date for 4 out of 10 sampled residents (Residents #17, #18, #23 and #24) who required assistance with the self-administration of medication.

The findings included:

During review of the MOR's, the following omissions and errors were identified:

1) Resident #17
a. 1:00 PM doses on were not initialed as given for C and .
b. 8:00 PM doses on were not initialed as given for and .

2) Resident #18
a. 9:00 AM dose on had not been initialed as given for Acidopholus.

3) Resident #23
a. 9:00 AM dose on had not been initialed as given for .

4) Resident #24
a. 1:00 PM dose on had not been initialed as given for .

The Resident Care Director was notified of these findings during interview on at 11:55 AM. The facility provided no additional documentation for review at the time of the survey.

Class III

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

Based on observation, record review and interviews, the facility failed to ensure that medications were

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stored in a secure manner and controlled substance medications accounted for on 3 of 3 medication carts (Cart #2,#3 & #4)

Findings include:
1) The surveyor was escorted to the first floor medication room on at 9:06 AM. Medication Technician A was inside the room and administering medications to a resident. The room contained a medication cart, a desk , a file cabinet and a table with a printer on top. Residents entered the room and sat in a chair while the Medication Technician poured their medications. On the top of the desk, the surveyor observed a bottle of , oral solution 250/mg/5 ml with the prescribed patient's name marked through. The surveyor picked up the bottle and noted that it still had liquid contents inside. A bottle of , , was also positioned on the table and a plastic bag containing numerous pill medications for a specific resident. Underneath, the desk was an open cardboard box with a large quantity of plastic bag packaged medications.

Medication Technician B entered the room and the surveyor asked who the bottle of , was prescribed for and why was it on top of the desk. The Technician stated that it was discontinued and she then picked up the bottle and threw it in the trash. The Surveyor asked why she had discarded the bottle which still contained some liquid medication. The Nurse Consultant entered the room at the same time and instructed the Medication Technician to first destroy the content before throwing the bottle away as part of the facility destruction procedure. The technician removed the bottle from the trash at the direction of the Consultant.

2) The surveyor then requested to review the Controlled Substance ( ) count records. The Surveyor asked Medication Technician A, if she counted the when she came onto the shift. She stated that she did so but that she did not sign the log sheet. Review of the sign on and out sheet for the 3rd floor revealed numerous discrepancies including the following:
missing signatures
missing signatures
missing signatures
no signatures
missing signatures
missing signatures
missing signatures
missing signatures
no signatures
no signatures
no signatures

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no signatures
no signatures
no signatures
missing signatures
no signatures
no signatures
no signatures
no signatures
no signatures
missing signatures
missing signatures

The surveyor then conducted a similar review of the 4th Floor Medication Cart attended by Staff B. Similar numerous discrepancies were identified including missing or completely absent signatures as follows: , , , , 415, , , , only one signature each day. No signature verifying a count was conducted on and .

Review of the 2nd Floor medication cart sign on and out sheets revealed discrepancies only on and . An interview was conducted with the Resident Care Director on at 12:20 PM. She confirmed that the technician coming on duty is responsible for counting the and affixing her signature on the log with the technician who conducts the count with her before turning over the keys. She could not explain why there was no evidence of a second medication technician signing the log on the three cart log books. She stated that she was unaware as she had not been monitoring the sheets.

The surveyor requested that a count be conducted on the 3rd floor by the medication technician and the Resident Care Director. During the count procedure, it was noted that there was a card of #60 , 2 mg tablets without a corresponding record sheet. The sheet is provided by the pharmacy when they deliver the cards and all doses removed from the card must be accounted for on the form. Althorough search of the Pharmacy documents was conducted by the Director and the Nurse Consultant which did not reveal the required document. The Pharmacy was notified of the discrepancy by the Nurse Consultant at that time.

An interview was then conducted with the Nurse Consultant who confirmed that the facility failed to ensure that medications were secured appropriately at all times and that controlled substance accounting measures implemented by the facility were followed to prevent diversion. She also confirmed that destruction of medications should be conducted by the Nurse and the Medication Technician by pouring the medications into a coffee slurry and not thrown into a trash can.

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Class III

0086 - Training - ADRD - 58A-5.0191(10) FAC

Based on record review and an interview, the facility failed to ensure that 2 out of 3 sampled staff, who have regular contact with or provide direct care to residents with ADRD (and Related) in this facility that maintains a secured area, had obtained 4 hours of initial training (Level I) within 3 months of employment (Staff C and D); and, failed to ensure 1 out of 3 staff had completed 4 hours of additional training in ADRD (Level II) within 9 months of employment (Staff C).; and, failed to ensure that 2 out of 3 sampled staff (Staff A and C) had completed 4 hours of annual update training in ADRD.

The findings included:

a) The personnel file for Staff A was reviewed for training in ADRD and did not contain documentation of 4 hours of annual training in ADRD from through . The following training was documented and available for review:

Staff A-Date of Hire
Level I and II (8 hours) completed
Level II (4 hours) completed
Annual Update (4 hours) completed

b) The personnel file for Staff C was reviewed for training in ADRD and did not contain documentation of the initial training in ADRD (Level I and II). The following training was documented and available for review:

Staff C-Date Of Hire
Annual Update (4 hours) completed

c) The personnel file for Staff D was reviewed for training in ADRD and did not contain documentation of any training in ADRD. Staff D was hired on . Level I training was due to be completed by .

During interview with the Assistant Administrator at 12:00 PM on , the aforementioned findings

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were discussed. The facility provided no additional documentation for review at the time of the survey.

Class III

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

Based on observation and interview, the facility failed to provide a living environment free of hazards and ensure that all structural systems, and appurtenances are maintained in good working order for 3 of 4 sampled residents residing at the facility.

The findings included:

Observational tours between the times of 9:00 AM and 4:00 PM on , , and revealed the following:

a) : The TV stand (provided by the facility) is deteriorating. Observations of the TV stand revealed that the drawer that goes on the TV stand is missing and the stand is not in good working condition.

b) Observations of the walls in revealed electrical extension hanging in the air in front of the entrance door and the closet door all connected into several electrical sockets. Resident # 11 was observed hanging clothes on a hanger from the cord and stated on between the times of 10:00 AM and 11:00 AM , that she puts her clothes there sometimes to dry.

c) : The floor was observed very sticky to the point of the surveyor's shoes were sticking to the floor after every step taken. Residents #11 and #12 stated on between the times of 10:00 AM and 11:00 AM, that it is like that before and after they mop the floors. Observations of the vinyl floors revealed various cracks and holes in the floor that could pose a safety hazard if the residents walk around their room without shoes. Both residents stated that the floors were like that before they moved in.

d) : Observations of the wall in the bathroom revealed a wall , that was observed out and when pushed in by the surveyor the went in revealing a hole in the wall that was plastered/painted over and not fixed properly.

e) : Observations of the wall revealed that the faceplate was missing for the phone jack. Observations of the area inside of where the faceplate should be revealed bug (unknown type) feces

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and bug skeletons. No information could be given from the residents in the room or from Administration on how long the area has been that way or if there are any live bugs inside of the walls. Observations of the tile floor in the room revealed cracks and dents from the front entrance of the room up until the bathroom posing a safety hazard if residents are walking around without shoes.

During an interview with the Administration Team (the Administrator, the Consultant, the Assistant Administrator, and the Facility's Nurse) on between the time of 1:00 PM and 2:00 PM the findings were discussed and acknowledged, no additional information was provided for review.

Class III