STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968790	10/22/2015
NAME OF PROVIDER OR SUPPLIER **ANGELS WINGS SYNERGY RETREAT, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1920 N 44TH ST** **FORT PIERCE, FL 34947**	

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

0000 Initial Comments

On 22, 2015, a limited nursing services monitoring survey was conducted at Angels Wings Synergy Retreat. The facility had deficiencies identified at the time of the survey.

0008 Admissions - Health Assessment

Based on record review and interview, it was determined the facility failed to ensure all residents had a medical examination completed within 30 days of admission and the findings documented on a Resident Health Assessment form (AHCA Form 1823), for 1 out of 4 residents (Resident # 2) .

Findings included:

During an interview with the Administrator on at 8:00 AM, the Surveyor requested the file for Resident #2 and the admission date of the resident. The Administrator stated, " I think it was around the first of the month. " However, the Administrator was not able to confirm the admission date. The Administrator stated, "she did not have any information on the resident except her drivers license and Medicare card for Resident #2." The Administrator stated that a DCF worker brought the resident to the facility. The Administrator confirmed that she did not have a completed 1823 form for Resident #2 and was unaware when the resident had last been examined by a physician. Surveyor made numerous attempts to interview Resident # 2, however, attempts were unsuccessful due to the resident's cognition.

Class III

0054 Medication - Records

Based on record review and interview, it was determined that the facility failed to ensure that resident's Medication Observation Record (MOR) is documented immediately upon observing a resident take his/her self -administered medications, for 3 of 3 sampled residents's MORs reviewed (Resident # 1, #3 and # 4).

Findings included:

The surveyor asked the Administrator to provide the Medication Observation Records for the facility on / at 8:22 AM. The Administrator stated that she had not been documenting the medications ordered for Residents # 1, # 3 and # 4. The Administrator then proceeded to look through a stack of documents to locate the previous Medication Observation Records for the residents. She handed the

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968790	10/22/2015
NAME OF PROVIDER OR SUPPLIER **ANGELS WINGS SYNERGY RETREAT, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1920 N 44TH ST** **FORT PIERCE, FL 34947**	

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

surveyor a Medication Observation Record for Resident # 4 dated , 2015. There were no medication records for the available for review for Resident #1, #2, #3 and #4 for the current month at this time. When asked if assisted residents with their medications, she stated, "yes". The Administrator stated she gave the mediations to the residents, but did not document this in any manner. At 12:30 PM on , while looking through the pile of document folders, the Administrator found Medication Observation Records for the three resident and handed them to the surveyor.

A) Review of the 2015 Medication Observation Record for Resident # 3 revealed only the following doses as being administered:

1) Entropies 1 mg twice daily , documented 6 doses being administered
2) , 3 doses documented on 10/8, 10/9 and
3) , 3 doses documented on 10/8, 10/9 and
4) , 3 doses documented on 10/8, 10/9 and
5) 20 mg daily , documented 3 doses on 10/8, 10/9 and
6) one daily, documented one dose on
7) 325 mg daily, none documented
8) DS 500 mg , ordered ,, none documented
9) patch one daily, none documented

B) A review of the Medication Observation Record for 2015 for Resident # 1 revealed only the following doses being administered:

1) 150 mg one daily , documented 3 doses on 10/9,10/9 and
2) 40 mg one daily, documented 3 doses on 10/8,10/9 and
3) 0.5 md one three times daily , documented 1 dose on 10/7, 3 doses on 10/8, 3 doses on 10/8 and 1 dose on
4) 100 mg at bedtime, documented 3 doses, one on 10/8, 10/9 and
5) 20 mg one daily, none documented

C) A review of the Medication Observation Record for 2015 for Resident # 4 revealed only the following doses being administered:

1) 10 mg twice daily, 1 dose on 10/7, 2 on 10/8, 2 on 10/9 and 1 dose on
2) 10 mg one daily , documented 3 doses on 10/8, 10/9 and
3) 2mg twice daily,documented 1 dose on 10/7, 1 dose on 10/8, 2 doses on 10/9 and 1 dose on
4) 1000 mg twice daily, documented 1 dose on 10/7, 2 on 10/8 2 on 10/9 and one dose on

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968790	10/22/2015
NAME OF PROVIDER OR SUPPLIER **ANGELS WINGS SYNERGY RETREAT, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1920 N 44TH ST** **FORT PIERCE, FL 34947**	

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

10/12
5) Loxapin 500 mg twice daily, 1 dose on 10/7, 2 on 10/, 2 on 10/9 and 1 on
6) 20 mg daily , one dose on 10/7 and 2 doses on 10/9
7) one daily, one dose documented 10/7, 10/8 and /
8) 25 mg on daily, none documented

The Administrator was interviewed, at this time, she was asked why there was no documentation on the MORs for the medications provided to each resident. The Administrator stated, "I just didn't do it, but would start doing so now. " The Administrator was asked, if she had received medication assistance training. She stated that she had only completed the 2 hour on line training and had failed to do the training with a Registered Nurse or Pharmacist, as required.

Class III

0055 Medication - Storage and Disposal

Based on record review and interviews, the facility failed to ensure that medications were secured at all times and keys unavailable to visitors and/or residents for 1 of 1 medication cabinets. The facility failed to ensure that discontinued medications were removed from the facility within 30 days after being discontinued for 2 of 3 residents (Resident # 3 and #4) .

Findings include:
1) The surveyor entered the facility on at 8:02 AM and asked the Administrator to show her where the medications were kept. The Administrator pointed to a kitchen cabinet which had a lock on the door. The surveyor asked the Administrator where the key was kept to the cabinet. The Administrator pointed to a key which was lying on the kitchen countertop and stated that she had a second key which she kept on a shelf inside another cabinet. When asked if visitors or residents had access to the kitchen, the Administrator confirmed that residents walk through the kitchen and that the key should be secured at all times.

2) A comparison of the physician orders to the medications stored for Resident # 3 showed a box of 2 mg and 650 mg for which the resident did not have an order. The Administrator was unaware that she should not retain medication for which there were no order. The Administrator stated that the medications were dropped off when the resident was brought to the facility in .

3) A comparison of the Physician orders to the medications stored for Resident # 4 showed a box of 2 mg and a box of 25 mg . The Administrator confirmed that there were no orders

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968790	10/22/2015
NAME OF PROVIDER OR SUPPLIER **ANGELS WINGS SYNERGY RETREAT, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1920 N 44TH ST** **FORT PIERCE, FL 34947**	

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

for the medications . The Administrator stated that the medications were dropped off when the resident was brought to the facility in and that they were not current medications. The Administrator stated that she was unaware that medications without orders should be stored separately or given to family/ responsible party and/ or removed from the facility within 30 days after discontinued use.

Class III

0084 Training - Assis Self-Admin Meds & Med Mgmt

Based on record review and interview, it was determined the facility failed to ensure that 2 of 2 employees who assist residents with their self-administered medication had completed a four hour training by either a Registered Nurse or a Pharmacist (Employee A, Employee B) prior to performing this task .

Findings included:

1) A review of the Employee training files for the Administrator, Employee A did not reveal evidence of a a four hour training in assistance with medication administration. The Administrator did provide a certificate dated credit for a 2 hour online course in medication administration for herself. The Administrator stated that when she had the initial survey, she was informed the 2 hour on line course did not meet the regulatory requirements and that she needed to take a four hour class from a Registered Nurse or a Pharmacist and failed to do so.

2) A review of the Employee training files for Employee B showed a 2 hour on line certificate verifying training in medication administration assistance. The Administrator confirmed that Employee B did not have the four hour required training before she administered medication to the residents.

Class III

0162 Records - Resident

Based on record review and interview, the facility failed to ensure that a record was maintained for 1 of 4 resident (Resident #2)

Findings included:

Upon arrival at the facility on / at 8:00 AM, the Surveyor asked the Administrator how may residents she had at the facility. The Administrator confirmed that she had four residents. The surveyor

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968790	10/22/2015
NAME OF PROVIDER OR SUPPLIER ANGELS WINGS SYNERGY RETREAT, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1920 N 44TH ST FORT PIERCE, FL 34947	

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

asked the Administrator how long Resident # 2 has resided at the facility. The Administrator stated, " I think it was around the first of the month. " Upon request for Resident #2's file; the Administrator stated that she did not have any information on the resident except her drivers license and Medicare card. The Administrator stated that the resident was placed by a third party under emergency placement services. However, Administrator had no documentation to support the emergency placement. The Administrator confirmed that she did not have a completed Health Assessment form (AHCA Form 1823) and was unaware when the resident had last been examined by a physician. The surveyor asked to see the contract for the resident, however, the Administrator sta that she did not have one yet. Attempts to interview Resident # 2 were unsuccessful due to the resident's cognition.

Class III

N277 LNS - Resident Care Standards

Based on interview and record review, it was determined the facility failed to ensure that a licensed nurse was employed to provide limited nursing services (LNS) under the facility's LNS license.

Findings include:

During an interview with the Administrator on , it was revealed the facility had not employed a nurse to provide LNS services under its license. The Administrator stated that she had not employed a licensed nurse and was unaware that she needed to do so as required for her Limited Nursing Services (LNS) license. The surveyor asked the Administrator if she had any policies or procedures for Limited Nursing Services and/or documentation requirements. The Administrator again confirmed that she was unaware that she needed to do so for her LNS license.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Angels Wings Synergy Retreat, LLC
1920 N 44th St
Fort Pierce, FL 34947

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure: 5000-3547
XG90

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida