STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966133	**02/07/2017**
NAME OF PROVIDER OR SUPPLIER **ATLANTIS ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **6026 OLD CONGRESS** **LANTANA, FL 33462**	

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

0000 - Initial Comments

Unannounced licensure complaint surveys, CCR#2016013066 & CCR#2016013404, were conducted on . . . . . & . . . . . at Atlantis Assisted Living (License #10424). The facility had deficiencies at the time of the investigation.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on interview and record review, it was determined the facility failed to be able to demonstrate they implement their grievance policy and procedure upon the receipt of a complaint for 3 of 7 sampled residents (Resident #2, Resident #4, and Resident #6). Based on interview and record review it was determined the facility failed to provide adequate and appropriate health care consistent with established and recognized standards within the community, specifically related to failure to provide , , medications per physician's orders for 1 of 7 sampled residents (Resident #1). Based on observation, interview, and record review, nit was determined the facility failed to honor each resident's right to privacy of their records which has the potential to affect all residents of this facility (current census of 68 residents).

The Findings included:

1) During interview and record review conducted with the Administrator, on beginning at approximately 9:45 AM, he provided a binder with the policy and procedure for filing a grievance/complaint to this surveyor. This binder only contained blank grievance forms and blank grievance logs. The Administrator was asked for the grievance logs since . . . . . . He replied that there had not been any filed. He stated if a concern is brought to his attention that it is handled immediately and that he does not document it on the grievance forms/logs. He said if there was a nursing concern that he believed that the DON (Director of Nursing) would make a note in the resident's record.

The facility's policy and procedure for Resident Grievance/Complaint, received by the Administrator on , indicated it is the policy that "All residents/resident representatives have the right to pursue a grievance/complaint with regard to their participation in the assisted living home. This assisted living facility will hear/listen and attempt to receive and review all grievance/complaints in a fair and timely manner". The procedure section indicated, "The grievance/complaint will be documented by facility staff member and forwarded to the Administrator on the Grievance log". "Staff personnel will meet with the concerned party and review the concern for resolution within 48 hours if not solved immediately. The resolution of the grievance/complaint will be signed by the Administrator and Resident upon completion". "The Administrator shall ensure that the outcome of the resolution is satisfactory to resident".

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a) During interview conducted with Resident #2's Representative, on beginning at approximately 3:40 PM, he was asked if he or his father had ever filed a grievance or reported any concerns to the facility Administrator or any facility staff. He replied that he had been in contact in person and via email, on many occasions, with the Administrator regarding incorrect pharmacy charges for medications that he had provided to the facility and that had been filled again by the facility's pharmacy. Also, he stated that he had provided 3 months worth of Lantus/Toujeo pens and that his father cannot use the vials (bottles) and needs the pens in order to self inject. He stated the facility kept ordering, from their pharmacy and he was charged for, vials of that his father was not capable to utilizing. He also stated he was not credited for these upon discharge and was not provided the vials upon discharge. He stated he still has no resolution for these incorrect charges and that basically the Administrator ceased to provide any assistance to resolve his reported concerns. He also stated that because he could not get assistance to resolve his reported concerns/grievances that Resident #2 is in the Medicare "donut hole" regarding his medications and is currently being charged at a much higher rate for his medications.

b) During interview with Resident #4, conducted on beginning at approximately 3:15 PM, he was asked if he had ever filed a grievance or reported any concerns to the facility Administrator. He replied that he has repeatedly reported to the Administrator that he cannot get his "as needed" pain medication on the 11-7 shift. He stated this has been going on for several months and that when he asks the 11-7 shift staff for his pain medication they tell him he will have to wait until the next shift (7-3) when the "Med Techs" come on duty. He stated the 11-7 shift staff stated there is no 11-7 shift "Med Tech" on duty and that they cannot open the medication cart. Resident #4 was asked if he ever filed out a grievance form about his concerns. He replied that he had not done that. However, he did state he has spoken with the Administrator on multiple occasions about not being able to receive his "as needed" pain medications on the 11-7 shift and that nothing is ever don't to correct it.

Review of Resident #4's health assessment, dated , indicated he is alert and oriented to person, place, and time. Review of his MORs (Medication Observation Records) from 2016 - 2017 did not reveal that he was provided with his physician ordered "as needed" pain medications (5-300mg every 6 hours as needed; 50mg twice a day as needed; / 5-300mg every 6 hours as needed) on the 11:00 PM - 7:00 AM shift.

c) During interview with Resident #6, conducted on beginning at approximately 10:20 AM, he was asked if he ever had any difficulty getting his medications in a timely manner. He replied that sometimes he has to wait a couple of hours for his pain medication when he asks for it on the 3-11 shift. He was asked about the 11:00 PM - 7:00 AM shift. He replied he has to wait until the next shift (7-3)

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because the 11-7 shift staff say they cannot give medications. He was asked if he had ever filed a grievance about this concern. He replied that he had not filed a written grievance, but that he has reported this to the Administrator on several occasions but nothing changes.

Review of Resident #6's health assessment, dated , indicated he is alert and , . Review of his MORs from , 2017 - , 2017 did not reveal that he was provided with any medications on the 11:00 PM - 7:00 AM shift. He is prescribed , 5mg every 4 hours as needed.

During interview conducted with the Administrator, on beginning at approximately 1:00 PM, he was asked if he was aware of the concerns noted above (regarding medications for Resident #2; Resident #4, and Resident #5). He acknowledged he was aware of these concerns but that he failed to document these reported concerns on a grievance form or anywhere else that he could recall.

Please see A0084 related to facility failure to maintain medication training documentation for all of their 11:00 PM - 7:00 AM shift staff.

2) Review of Resident #1's MOR (Medication Observation Record) for 2016 revealed tablet 0.1mg is to be provided twice daily as needed (if , is greater than). The 2016 MOR did not reflect that this medication was provided to Resident #1. However, the 2016 MOR reflected his , exceeded the established parameters on the following dates:
a) :
b) :
c) :
During interview and review of Resident #1's record conducted with the DON (Director of Nursing), on beginning at approximately 11:15 AM, she acknowledged this resident's , was noted to be greater than the established parameters on the above noted dates. She was provided the opportunity to locate any documentation related to the provision of the or that the nurse contacted the physician to notify that his , was outside of the established parameters. She could not locate this documentation.

3) Observation of the Nurse's Station/DON's (Director of Nursing) office, conducted on beginning at approximately 8:00 AM, the door was unlocked; the medication cabinets were unlocked; all residents medical charts were accessible; there was no staff present in this seen on this hall at the time of this observation.

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During observation and interview with Staff D (Med Tech), conducted on beginning at approximately 8:25 AM, she acknowledged that the Nurse's Station/DON's office was unlocked. Staff D acknowledged that the medication cabinets (x 2) were unlocked and contained medication from , to . Staff D also acknowledged that no staff was present or in the area of the Nurse's Station at the time of this observation and that all resident medical records are kept in this .

The DON entered the Nurse's Station (her office) on at approximately 8:30 AM. She was informed that Staff D and this surveyor found this and unattended. The DON acknowledged that the expectation is for the door to be locked unless staff is in the the medication cabinets are to be locked unless staff is utilizing these cabinets (photos obtained).

The above noted concerns were discussed with the Administrator on beginning at approximately 8:42 AM. He acknowledged that the expectation is for that be locked and for medications to be double locked unless staff is present.

Review of the facility's policy and procedure related to Resident's Records, provided by the facility's RNC (Registered Nurse Consultant) on , indicated the facility will maintain a systematic and secure method of identifying and filing resident health records for easy access.

Class III

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

Based on observation, interview, and record review, it was determined the facility failed to ensure that unlicensed staff the provide assistance with the self-administration of medications did so in accordance with procedures described in Section 429.256, F.S. and this rule, for 1 of 4 sampled residents observed for medications (Resident #7).

The Findings included:

During observation of Staff D, conducted on beginning at approximately 8:05 AM, she obtained the following medications for Resident #7 from the medication cart: Donepizil 10mg; /Vit D 600; and XR 14mg. Staff D then proceeded to place these three pills into a small plastic cup of applesauce. She then mixed the pills in with the applesauce and spoon fed this entire mixture into Resident #7's mouth. Resident #7 did not participate in spooning any of this mixture into her own mouth.

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During interview conducted with the facility's RNC (Registered Nursing Consultant) and the DON (Director of Nursing), on beginning at approximately 11:20 AM, they were asked how a staff member that provides assistance with the self administration of medications is to provide assistance for a resident whose medications are placed in applesauce. The facility's RNC stated the staff could place the medication in the applesauce and mix it and even hand the spoon to the resident, but that the resident had to bring the spoon to their mouth. She was asked if it would be appropriate for the staff member to place the medications in the applesauce; mix the medications; and for the staff member to spoon feed all of this mixture into the resident's mouth without any participation from the resident. The RNC agreed that if this was the case that this was not providing assistance with the self administration of medications that it would be considered medication administration. The facility's RNC and the DON were informed of the observation noted above with Staff D.

Class III

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

Based on interview and record review, it was determined the facility failed to ensure the medication records were complete, for 1 of 7 sampled residents (Resident #5).

The Findings included:

During interview and record review conducted with the DON (Director of Nursing) on beginning at approximately 11:25 AM, Resident #5's , 2017 and , 2017 MOR (Medication Observation Record) was reviewed. These MORs indicated " Patch 4.6mg/24 - apply , to affected area(s) once daily (remove old patch) *Rotate Site". The DON acknowledged that the MORs do no indicate site rotation for the patch for Resident #5. She was provided the opportunity to locate any documentation related to site rotation and was not able to find any.

Class III

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

Based on observation, interview, and record review, it was determined the facility failed to ensure that centrally stored medication are locked at all times.

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The Findings included:

Observation of the Nurse's Station/DON's (Director of Nursing) office, conducted on beginning at approximately 8:00 AM, the door was unlocked; the medication cabinets were unlocked; all residents medical charts were accessible; there was no staff present in this seen on this hall at the time of this observation.

During observation and interview with Staff D (Med Tech), conducted on beginning at approximately 8:25 AM, she acknowledged that the Nurse's Station/DON's office was unlocked. Staff D acknowledged that the medication cabinets (x 2) were unlocked and contained medication from , to . Staff D also acknowledged that no staff was present or in the area of the Nurse's Station at the time of this observation and that all resident medical records are kept in this .

The DON entered the Nurse's Station (her office) on at approximately 8:30 AM. She was informed that Staff D and this surveyor found this and unattended. The DON acknowledged that the expectation is for the door to be locked unless staff is in the the medication cabinets are to be locked unless staff is utilizing these cabinets (photos obtained).

The above noted concerns were discussed with the Administrator on beginning at approximately 8:42 AM. He acknowledged that the expectation is for that be locked and for medications to be double locked unless staff is present.

Review of the facility's policy and procedure related to Resident's Records, provided by the facility's RNC (Registered Nurse Consultant) on , indicated the facility will maintain a systematic and secure method of identifying and filing resident health records for easy access.

Class III

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

Based on interview and record review it was determined the facility failed to ensure when a medication is prescribed "as needed" or "as directed" the health care provided was contacted and requested to provide revised instructions to include the circumstances under which it would be appropriate for the resident to request the medication and any limitations to be specified (for example: as needed for pain,

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not to exceed 4 tablets per day) for 2 of 7 sampled residents (Resident #5 and Resident #6).

The Findings included:

1) During interview and record review conducted with the DON (Director of Nursing), on at approximately 11:30 AM, the following resident's MORs (Medication Observation Records) were reviewed:

a) Resident #5: " tablet 5mg one tablet by mouth twice daily as needed"
b) Resident #6: " tablet 5mg one tablet by mouth every 4 hours as needed"

The DON acknowledged that the MORs do not include a reason for why the medication is needed (for example: for pain). She also acknowledged that limitations were not noted as well (for example: not to exceed 4 tablets per day).

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on interview and record review it was determined the facility failed to ensure adequate Medication Training documentation was maintained for 3 of 3 sampled staff (Staff A, Staff B, and Staff C).

The Findings included:

During interview and personnel record review conducted with the BOL (Business Office Liaison), on beginning at approximately 2:30 PM, she confirmed the only Medication Training certificate on file for Staff A (date of hire noted as) was for 4 hours and was dated . She also acknowledged that this certificate did not indicate who the trainer was and their credentials. This certificate only noted "Director" and "Faculty Member" signatures. The BOL acknowledged that Staff A did not have the documentation of Medication Training needed to provide assistance with the self-administration of medications for the residents of this facility. The BOL also confirmed that Staff A works the 11:00 PM - 7:00 AM shift.

During interview and personnel record review conducted with the BOL, on beginning at approximately 2:30 PM, she confirmed the only Medication Training certificates on file for Staff B (date of hire noted as) was a 2 hour update dated that did not include the credentials of the trainer; a 4 hour initial Medication Training certificate dated by a Registered Nurse was located; the Administrator located and provided for review a Medication Training certificate for 4 hours

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that was dated by a Registered Nurse. The BOL acknowledged that there were no other Medication Training certificates on file for Staff B. She also acknowledged there was no documentation of continuing education (annual 2 hour update) for Staff B on file from , 2005 - , 2016. Therefore, from Staff B's date of hire through she did not have documentation of Medication Training and would not have been able to provide assistance with the self-administration of medication for the residents of this facility. The BOL also confirmed that Staff B works the 11:00 PM - 7:00 AM shift.

During interview and personnel record review conducted with the BOL, on beginning at approximately 2:30 PM, she confirmed that the only Medication Training certificates on file for Staff C (date of hire noted as) was a 5 hour training dated that did not include the credentials of the trainer; a 4 hour Medication Training certificate dated by a Pharmacist; a 4 hour training dated by a Registered Nurse. The BOL acknowledged the first noted Medication Training certificate was dated and that there were no Medication Training certificates on file from date of hire through . She also acknowledged that Staff C did not have documentation of Medication Training from - and would not have been able to provide assistance with the self-administration of medications for the residents of this facility. The BOL also confirmed that Staff C works the 11:00 PM - 7:00 AM shift.

Please refer to A0030 related to grievances regarding residents not being able to get as needed medications on the 11-7 shift.

Class III