STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966133	**07/25/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIS ASSISTED LIVING	**6026 OLD CONGRESS LANTANA, FL 33462**

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

0000 - Initial Comments

A monitoring inspection survey was conducted on at Atlantis Assisted Living facility (License #10424). The facility had deficiencies identified at the time of the survey.

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

Based on observation and interview, the facility failed to provide a decent living environment by not allowing the residents use the facility's lobby while the residents were inside the main dining .

The findings are:

In an interview with resident #1 on at 9:05am, he stated that the facility staff members did not allow him to use the common located in the lobby while he ate his meals in the main dining immediately next to the lobby. He stated that whenever he needed to use the between his daily meals, he was told by numerous facility staff members, including the administrator and the receptionist, that he needed to go to his private or another common on the opposite end of the facility. He stated that since he needed to use his wheelchair to ambulate, it took him a very long time to reach the his at the opposite end of the facility. He stated that he was used to using the immediately before or after, and during his daily meals and it was difficult for him to not be able to use the lobby , which were next to the main dining .

In an observation on from 9:10am to 9:45am, it was determined that two facility lobby were located immediately next to the main dining the east wing of the facility, no other common were located on the east wing of the facility and the other common were located on the north, south and west wings of the facility, which were over 150 feet away from the interior of the main dining . It was also noted during this observation that the resident were also located on the north, south and west wings of the facility.

In an interview with resident #3 on at 10:25am, she stated that the facility staff members, including the administrator and the receptionist, did not allow her to use the common located in the lobby while she ate her meals in the main dining immediately next to the lobby. She stated that it took her several minutes to just ambulate from the main dining her way, and her meal would be by the time she returned to go to her private her own . She stated that the inability for her not to be able to use the nearby lobby , during or around meal time while she was in the main dining inconvenient at best and painful

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at worst if she had to hold her until she reached her private her .

In an interview with the facility receptionist on at 10:35am, she stated that it was present facility procedure to not allow residents to use the common lobby at any time or during meals while the residents were inside the main dining . She stated that this procedure was in place for approximately 6 months and it was enacted after a few residents suffered accidents inside the common lobby while they used the without personal supervision from the facility staff. She stated that an unaccompanied resident about 6 months ago got stuck inside a locked lobby having suffered a , and it was difficult for the facility staff to enter this locked assist this resident. She stated that she followed the facility procedure to not allow residents to use the common lobby despite the daily requests from numerous residents she received to use these . She stated that whenever a resident asked to use the lobby , she recommended to these residents to go to their own to use the , which were located on the other wings of the facility.

Class III

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

Based on observation and interview, the facility failed to return the medications for 8 out of 8 discharged residents (residents #5, 6, 7, 8, 9, 10, 12 and 13) and it failed to determine the expiration of two medications for 1 out of 1 current resident (resident #11).

The findings are:

In an observation on from 9:30am to 9:55am in the facility's medication , the following residents' medications were centrally stored:

1. Resident #5's , 0.5mg tablets with expiration on .
2. Resident #6's 0.1% cream with expiration on and Nyamyc 100,000 units/gm power with expiration on .
3. Resident #7's , 0.4-0.3% gel eye drops with expiration on .
4. Resident #8's 50-500mg tablets.
5. Resident #9's 12% cream.
6. Resident #10's , 20mg capsules and , 5mg tablets.
7. Resident #11's 150mg tablets with expiration on and 20mg tablets with expiration on .
8. Resident #12's 25mg capsules with expiration on .

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9. Resident #13's , LA 15mg tablets with expiration on .

In an interview with the administrator on at 9:50am, he stated that the medication the facility's centralized location to store current and discharged resident medications and it was accessible by the facility staff that handled the residents' daily medications. He stated that residents #5, 6, 7, 8, 9, 10, 12 and 13 were discharged from the facility over 30 days ago and that the facility did not return or make any effort to return these medications to the residents, their families or their guardians after the residents left the facility. He stated that resident #11 was a current resident in the facility and that the facility did not determine that this resident's 150mg tablets and 20mg tablets, as they were centrally stored in the facility's medication , were expired.

Class III