STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966133	**10/31/2018**
NAME OF PROVIDER OR SUPPLIER **COLONIAL ASSISTED LIVING AT PALM BEACH COUNTY, FL**	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

An unannounced relicensure survey was conducted on [redacted] at Colonial at Palm Beach, License # 10424. The facility had deficiencies at the time of the visit.

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

Based on observation, interview and record review, it was determined that the facility failed to ensure that prescriptions for residents who receive assistance with self-administration of medications are filled or refilled in a timely manner. As evidenced by the facility staff not following facility protocol and policy to ensure timely refills of residents' medications for all sampled residents residing at the facility.

The findings included:

Review of the facility's medication re-ordering policy revealed that the medication supply will be replenished on a weekly basis by (name of Pharmacy) and that the pharmacy will do a weekly check and report all concerns to the Administrator for correction. The physician will be contacted by the Director of Nursing/Wellness Director during the week for prescriptions and refills. If needs occur after hours, the on duty Medication Tech will perform this duty. The (name of Pharmacy) will be called if medications supply is 5 days or less without receipt of mail in medications-timely. As a backup alternative, the facility may contact the (name of entity) residents physician after approval and order a temporary supply of medication from (name of Pharmacy) if mail orders do not arrive timely so there is no missed medication dose.

During confidential family interviews and resident interviews conducted on [redacted] between the times of 9:00 am and 3:00 pm , it was revealed that the facility does not ensure residents' medications are filled in a timely manner. During confidential family interviews, it was revealed that medications are not being ordered timely and that it has been a struggle getting medications re-ordered. It was also revealed that sometimes, family members of the residents have to go pick the medications up themselves to stop from missing a dosage. Confidential resident interviews also revealed the same concerns. It was recently revealed that during an attempt to have medications refilled with the assistance of the Medication Techs on the weekend shift, the resident was told they do not order medications and that someone that works Monday through Friday does the medication ordering and that the resident will have to wait until then to tell someone.

During an interview with Unlicensed Staff (Staff A) on at 11:47 am, it was stated that the Health and Wellness Director usually orders the medications. It was further stated that when the Health

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and Wellness Director is not here on the weekends than the Medication Techs on each shift are the ones that supposed to order the medications if a resident is running low or out of medications.

During an interview with the Health and Wellness Director on [redacted] at 10:23 am, it was stated that all the Medication Techs are trained to order medications and that they are the ones that should be ordering the medications if they are aware that the resident needs more or is running low.

Review of the job description for the Medication Techs states that the Medication Techs are responsible in ensuring each person has their medications timely. This includes the ordering of the medications.

During an interview with the Administrator, the Consultant, and the Health and Wellness Director at 4:00 pm on [redacted] revealed that there is not a set system in place or a set person responsible for ordering the medications and ensuring that each resident receives their ordered medication timely without missing any dosages. The findings were acknowledged and discussed, no additional information was provided for review.

Class III

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

Based on record review and interview, it was determined that the facility failed to maintain a safe and clear environment for residents.

The findings included:

1) Observations of the [redacted] visitors and residents near the nurses station and hair salon revealed that the [redacted] does not lock and is missing the button to lock the door on the inside of the door handle. Further observations revealed that the knob on the faucet is broken.

2) Observations of the [redacted] the activity [redacted] the surveyors were station for a second day on [redacted] revealed that there was a hole in the wall that was patched and drying that had not yet been painted over. Observations of the patch revealed that it was larger than the boxed fan that sat on the floor drying the dry wall paste used to cover up the hole. Further observations of the boxed fan that the Mainentaniance personnel left in the [redacted] into the wall revealed a safety hazard once residents, staff, or visitors used the [redacted] would have to reach over the chord plugged into the wall. Observations of the wall socket that is located next to the paper towel dispenser reveals an

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electrical hazard when attempting to get paper towel with wet hands. Additional observations revealed unmatched knobs on the for hot and water.

3) On at 10:00 AM, a tour was conducted on the South unit. It was revealed that there was a foul odor in the hallway. The surveyor noticed the foul smell was coming from the dirty mop bucket. The water was brown and smelled foul in the front of #

On at 03:30 PM, an interview was conducted with the Administrator and the Nurse Consultant. They acknowledge the findings.

Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on interview and record review, it was determined that the facility failed to ensure that the Comprehensive Emergency Management Plan was submitted annually to the local Emergency Managment Division for review and approval.

The findings included:

On a review of the facility documents reveal the CEMP form was submitted for approval after the expiration date. The receipt for the approval is dated . A review of the CEMP for the previous year shows that the CEMP expired on . Therefore, the facility was unable to provide proof of the facility's current CEMP approval.

On at 11:30 AM, an interview was conducted with the Administrator. He acknowledged the findings.

Class III

Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on interview and record review, the facility failed to ensure that the Level II Background screening was completed in a timely manner, for 1 of 3 Staff reviewed (Specifically, Staff D).

The findings included:

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On . . . . . a review of the facility documents revealed the Level II Background screening had not been renewed before the expiration date for Staff D. On a review of the employee records reveal Staff D is a Certified Nursing Assistant (CNA) that provides direct care to the residents of the facility. It was determined that her initial screening was conducted .

The requirement is not met, as the Level II Background screening must be updated every five (5) years and yield a result of Eligible for the licensing agency. This requirement alerts the facility of any felony violations committed by their employee.

On at 03:30 PM, an interview was conducted with the facility Nurse Consultant in which the findings were discussed.

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Unclassified