PRINTED: 10/12/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (Y2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER:

A. BUILDING B. WING 105492 09/22/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1626 DAVIS RD CONSULATE HEALTH CARE OF WEST PALM BEACH WEST PALM BEACH, FL 33406 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE OPERIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LISC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 000 INITIAL COMMENTS F 000

F 248

An unannounced Recertification survey was conducted on 09/19/2016 through 09/22/2016 at Consulate Healthcare of West Palm Beach. The facility is not in compliance with 42 CFR Part 483. Requirements for Long Term Care Facilities. F 248 483.15(f)(1) ACTIVITIES MEET

SS=D: INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

> This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide activities in accordance with the comprehensive assessment and interest of the residents, for 1 (Resident #217) of 3 residents reviewed for Activities, of a sample of 17 residents interviewed.

The findings included:

During an interview on 09/20/16 at 9:18 AM Resident #217 was asked, "Does staff provide items so you can do activities on your own, like books or cards?" Resident #217 responded, "No." During this interview Resident #217 explained that she is at the facility because of an An device was to her The resident also noted to her right explained that it is difficult for her to get out of bed, and that she prefers to be in her room. She stated that she prefers independent activities.

Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies, the plan

This plan of correction will serve as the Facility's allegation of substantial compliance

State and Federal law.

of correction is prepared and submitted solely because of the requirements under

What corrective action(s) will be accomplished for those residents affected by the deficient practice?

Resident #217 Activity of choice was reviewed with

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(Y6) DATE

Electronically Signed

10/11/2016

10/22/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

PRINTED: 10/12/2016 OMB NO. 0938-0391 (X3) DATE SURVEY

FORM APPROVED COMPLETED

105492

R WING

09/22/2016 STREET ADDRESS CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

CONSULATE HEALTH CARE OF WEST PALM BEACH

1626 DAVIS RD

WEST PALM BEACH, FL 33406 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) MPLETION DATE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEEICIENCY)

F 248 Continued From page 1

On 09/20/16 at 3:14 PM and 09/21/16 at 10:34 AM Resident #217 was noted to be out of her room. As per her roommate, Resident #217 was at physician appointments

During a subsequent interview on 09/21/16 at

12:50 PM Resident #217 stated that she was frustrated as she has had numerous physician appointments, and when she returns she is worn out, again stating that she prefers to be in her room. When asked again if staff have offered her anything to do in her room, she stated they had not. When asked if she had any books or cards she again stated that she did not have either, and : volunteered, "I live for cards." Resident #217 explained that she plays cards with a group and enjoys Solitaire. She stated that she bought an electronic Solitaire game, but can't get it to work. When asked if she would like a deck of cards, Resident #217 stated that she would love a deck of cards to play Solitaire.

Review of the record revealed Resident #217 was admitted to the facility on with diagnoses Review of the to include a admission MDS (Minimum Data Set) comprehensive assessment dated documented Resident #217 has a BIMS (Brief Interview for Mental Status) score of out of . Review of the indicating she is and Activity Preferences section of this assessment documented it is very important for her to have books, newspapers and magazines to read. This comprehensive assessment also documented

that it is very important for her to have her favorite

Review of the Activities Evaluation, completed on

F 248

resident and a deck of cards was provided.

How we will identify others having the potential to be affected by the same deficient practice and what corrective action will be taken: Current residents were re-interviewed for

their preferences in activities, changes were made accordingly. What measures will be put into place or what systemic changes will be made to

ensure that the deficient practice does not recur: Activity director and staff were in-serviced on providing activity per resident choice and interest. Activity director will review new admission and current residents on

their initial and quarterly assessment to

ensure resident received activity of their choice. AD/designee will report findings monthly to QA until substantial compliance is maintained

activities.

PRINTED: 10/12/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 105492 09/22/2016 STREET ADDRESS CITY STATE ZIP CODE NAME OF PROVIDER OR SUPPLIER 1626 DAVIS RD CONSULATE HEALTH CARE OF WEST PALM BEACH WEST PALM BEACH, FL 33406 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (FACH CORRECTIVE ACTION SHOULD BE (FACH DEFICIENCY MUST BE PRECEDED BY FULL DREEIY REGULATORY OR LSC (DENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 248 Continued From page 2 F 248 by the Activities Director, documented Resident #217 was and interested in activities, cooperative and motivated. This assessment documented current interests that are very important to the resident as animals/pets, cards, family/friend visits, movies, music, reading and television. Although this assessment documented the card interest as a "small group" activity, Resident #217 stated that she enjoys both small group and independent playing of cards. Review of the current activities care plan documented Resident #217 prefers to stay in her room and that her interests included card games. coffee hour, food, snacks, in room visits, music, book club, and TV. During an interview on 09/22/16 at 12:30 PM the Activity Director confirmed she completes the activities initial assessments. When asked about Resident #217, the Activity Director stated that

be in

she doesn't like to be in groups and she wants to

. The Activity Director further stated that Resident #217 is very friendly, likes to watch TV. and likes to read. The Activity Director stated she offered Resident #217 magazines and books when she first got here. Stated that she offers items to read each Friday by going door to door with a cart. When asked if she documents this or documents if any resident accepts anything, the Activity Director stated that she does not. The Activity Director agreed that her assessment for Resident #217 included cards, and stated that she never thought to offer her cards as she "had a Solitaire game on the machine." When told that her machine didn't work the Activity Director stated that she did not know that. When asked if

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by:

assessment.

penalty of not more than \$5,000 for each

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced

Based on observation, interview and record

What corrective action(s) will be

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING

105492

B. WING

09/22/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CONSUL	ATE HEALTH CARE OF WEST PALM BEACH		1626 DAVIS RD WEST PALM BEACH, FL 33406			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 278	Continued From page 4	F 27	8			
	review the facility failed to ensure accurate MDS (Minimum Data Set) assessments for 2 (Resident #103 and #46) of 6 sampled residents reviewed		accomplished for those residents affected by the deficient practice?			
	for behaviors and unnecessary medication reviewed for behaviors and unnecessary medication review, of a total of 19 residents whose MDS assessments were reviewed.		Resident #46 and #103 were reassessed to reflect their behavior and their medication administration.			
	The findings included:		Social worker in-serviced on the importance of the accuracy of coding resident behavior.			
	An observation on 09/20/16 at 3:03 PM revealed Resident #103 quietly lying in bed with her eyes closed. A (an device used for residents at risk for) was noted to her right During a subsequent observation on 09/21/16 at 2:25 PM Resident		How we will identify others having the potential to be affected by the same deficient practice and what corrective action will be taken:			
	#103 was observed in the common area, sitting next to her and conversing in with staff.		Current resident's MDS with behavior and medication administration were reviewed: those affected by this alleged deficient practice were corrected			
	Review of the record revealed Resident #103 was admitted to the facility on // with diagnoses		accordingly.			
	to include and Review of the 90 day significant		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not			
	change MDS (Minimum Data Set) assessment dated documented Resident #103 exhibited behavioral symptoms directed		recur:			
	exhibited behavioral symptoms directed					

of one week. Review of the monthly Behavior Symptom Monitoring Flow records for the months of 2016 lacked any documented 2016 through behaviors. Review of the nurse's notes for the

Resident #103 was doing fair, no overt

to 3 days during the assessment look back period

toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others

2016 lacked any documented month of behaviors. Review of the Medication e Medical Follow-Up visit dated

will review MDS assessment weekly to ensure accuracy.

Facility ID: 95032

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.

MDS/CP teams were in-serviced on MDS

accuracy. MDS coordinator or designee

MDS coordinator or designee will report

findings to QA monthly until substantial compliance is maintained.

PRINTED: 10/12/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 105492 B. WING 09/22/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1626 DAVIS RD CONSULATE HEALTH CARE OF WEST PALM BEACH WEST PALM BEACH, FL 33406 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 278 : Continued From page 5 F 278 patient is with no complaints and no . Review of the Mediation Evaluation dated // documented the only behaviors as refusing to get out of bed and at times, and During an interview on 09/21/16 at 2:31 PM, Staff N, the CNA (Certified Nursing Assistant) assigned to Resident #103, who has worked at the facility for 3 years, stated Resident #103 does not have any behaviors, and hasn't had any. Staff N stated Resident #103 has always been nice. During an interview on 09/21/16 at 2:38 PM, Staff G. the RN (Registered Nurse) assigned to Resident #103, who has worked at the facility for about 5 years stated the resident likes to stay in her room or with her roommate. Staff G stated Resident #103 was transferred to this unit on . When asked if the resident has any behaviors, Staff G stated that she sometimes doesn't want to go to the dining room, and that she has a poor appetite. Staff G stated the resident was , thus the was placed. Staff G stated that she had not seen any behaviors for Resident #103 and

confirmed that if the resident had had any behaviors, she would document them on the Behavior Symptoms Monitoring Flow Sheet. On 09/21/16 at 4:28 PM Staff E, an RN and Unit Manager confirmed documentation of behaviors are on the Behavior Symptoms Monitoring Flow Sheet, and stated the resident's behavior for has improved.

During an interview on 09/21/16 at 4:34 PM the SSD (Social Services Director) confirmed she

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assessment, dated

 50 mg, to be administered each morning A review of the Annual MDS assessment, dated , and the latest quarterly MDS

, shows no medication being administered on any day during the lookback periods for either of these assessment dates; however, these same

PRINTED: 10/12/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING 105492 B. WING 09/22/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF DROVIDED OR SUPPLIED 1626 DAVIS RD CONSULATE HEALTH CARE OF WEST PALM BEACH WEST PALM BEACH, FL 33406 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 278 Continued From page 7 F 278 do document the administration of an on all 7 days of the lookback periods. A review of the physician order summary for . ≥2016 and 2016 documents the medication was on the Medication Administration Summary for both months and should have been administered each day during these months. No documenation or additional physician orders showing changes in the original order for daily administration of 3 F was found within the resident's medical record. A review of the MAR for Resident #46 documents medication, 1, 75 mg, was administered to this resident every evening at bedtime from . I, 2016 -, 2016 and from , 2016. 1, 2016 -F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO F 280 10/22/16 SSED PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to

participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,

91

		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 10/12/20 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		105492	B. WING_		09/22/2016
	ROVIDER OR SUPPLIER	OF WEST PALM BEACH		STREET ADDRESS, CITY, STATE, ZIP CODE 1626 DAVIS RD WEST PALM BEACH, FL 33406	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLETIC
F 280	the resident, the re-	age 8 racticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after	F 2	30	
!	by: Based on observareview the facility fafor 2 of 19 resident Resident #64's can concerning the add	NT is not met as evidenced tion, staff interview, and record alied to update the care plan s reviewed. Resident #161 and e plans were not revised littion of for bathing preferences for		What corrective action(s) will accomplished for those reside by the deficient practice? Resident #161 care plan was reflect, medication Resident #61 care plan was reflect bathing preference.	nts affected reviewed to n usage.
	#161 was admitted diagnoses which in features. changed her medic medical a day. A review of resident did not ad	clinical record reveals Resident I to the facility on with included with		How we will identify others hav potential to be affected by the deficient practice and what cor action will be taken. Current residents with medication their care plan wer none were identified of this all deficient practice.	same rrective e reviewed eged

medications was not checked for the resident. On 9/20/16 at 4:13 PM, the Director of Nursing acknowledged the care plan had

omissions. In an interview on 09/21/2016 10:06 AM the MDS consultant stated the addition of the alone would not trigger a significant change on the Minimum Data Set (MDS), but the

care plan should have been updated to include the

recur:

Facility ID: 95032

addressed accordingly.

ensure bathing/shower and refusals were

What measures will be put into place or what system changes will be made to

CP team were in-serviced on care plan

ensure that the deficient practice does not

If continuation sheet Page 9 of 43

PRINTED: 10/12/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING 105492 B. WING 09/22/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF WEST PALM BEACH WEST PALM BEACH, FL 33406 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ١D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 280 F 280 Continued From page 9 accuracy. CP coordinator or designee will 2) During an interview on 09/19/16 at 2:00 PM medication, bathing preference and refusals weekly to ensure Resident #64 was asked, "Do you choose how many times a week you take a bath or shower?" accuracy. Resident #64 responded "No, I only get bed baths." During a subsequent interview on How the corrective action(s) will be monitored to ensure the deficient practice 09/20/16 at 3:25 PM Resident #64 confirmed that she isn't getting showers. She stated that she did will not recur, i.e. what quality assurance get one a week or so ago and "They decided that program will be put into place. they can't do it. It's because my is so During a third interview on 09/22/16 at 9:41 AM Care plan coordinator/designee will report findings monthly to QAPI until substantial Resident #64 stated that when she tried compliance maintained. showering awhile back, it was difficult and "the girls thought I was too " so the resident decided bed baths were ok. Resident #64 stated that she has gotten occasional showers, but would like more. Resident #64 stated that she hasn't told anyone recently about her desire for more showers. Review of the record revealed Resident #64 was

admitted to the facility on

bed bath or sponge bath.

Review of the physician orders for 2016 documented, "Daily bed bath per patient preference." This order was originally from __// , Review of the MDS Kardex for use by the CNA's (Certified Nursing Assistants), it was handwritten in large letters, "Refuses showers."

significant change MDS (Minimum Data Set)

Resident #64 has a BIMS (Brief Interview for Mental Status) score of indicating she has problems. This MDS assessment also documented the resident stated it was somewhat important to choose between a tub bath, shower,

readmission on

assessment dated

Facility ID: 95032

Neview of the

documented

PRINTED: 10/12/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 105492 B WING 09/22/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1626 DAVIS RD CONSULATE HEALTH CARE OF WEST PALM BEACH WEST PALM BEACH, FL 33406 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES in (X5) COMPLETION DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 280 Continued From page 10 F 280 Review of the current care plans for Resident #64 lacked any documentation of the order for bed baths per resident preference or of the resident's refusal of showers. The current ADL (activities of daily living) care plan simply documented numerous intervention for the provision of bathing. The only intervention related to showers documented, "Provide resident with a sponge bath when a shower cannot be tolerated." This

years confirmed that Resident #64 needs to for that she gets both bed baths and showers, but sometimes refuses the showers.

During subsequent interviews on 09/22/16 at approximately 10:30 AM both the Unit Manager and DON (Director of Nursing) stated that they have tried showers in the past, and Resident #64 gets very upset with the process. The DON agreed that the care plan lacked the refusal of showers and order for bed baths, and agreed that it had not been revised.

During an interview on 09/22/16 at 8:52 AM Staff H. a CNA who has worked at the facility for 7

ADL care plan was initiated on // recently updated on

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Facility ID: 95032

F 309

10/22/16

SS=D HIGHEST WELL BEING

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The resident was scheduled to receive treatments in a community facility three days a week leaving the facility at 12:30 PM and returning after 5:00 PM on Monday, Wednesday and Friday. The following monthly physician orders were not followed to ensure the resident received the prescribed medications as ordered on days:

A physician order prescribed for the resident to receive 50 mg give one tablet by mouth once daily. Hold on days until after on Monday, Wednesday, and Friday. Administration time of 9:00 AM. The Medication Administration Record (MAR) documented the prescription and noted the nurses placed their initials in the appropriate boxes indicating the medication was

What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recur:

Nursing staff were educated on following doctor's order of residents. Unit Manager will check MAR twice weekly to ensure accuracy.

Findings will be reported to the DCS.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place

DCS/designee will report findings to QAPI monthly until substantial compliance is

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	KS FUR MEDICARE	& MEDICAID SERVICES				JIVID INU. U	930-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		DISTRUCTION	(X3) DATE SURVEY COMPLETED		
		105492	B. WING			09/22	2/2016	
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
CONSUL	ATE HEALTH CARE	OF WEST PALM BEACH			DAVIS RD T PALM BEACH, FL 33406			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE '	(X5) COMPLETION DATE	
F 309	Continued From pa		F	309				
	differentiation on was held and given	days that the medication after for 6 of 8 times						
	the resident went to	o in on , and .						
	resident to receive	sician order prescribed for the : 0.1 mg by mouth : greater						
	every 8 hours for than hold for administration time 10:00 PM.	less thar with s of 6:00 AM, 2:00 PM and						
	The MAR d PM dose, the nurse	ocumented 7 times at the 2:00 e circled their initials indicating was not administered (
		ent was at at 2:00 PM). of the MAR documented 2 of						
	the 7 circled doses	on and the because the resident was at						
	AM with Staff C, R	onducted on 09/21/16 at 9:25 egistered Nurse, regarding e resident. She stated she						
	gives the 9:00 AM indicated. She will	medications to the resident as	i					
	give the resident the because her she needed to folk	ne medication had been but						
	AM with Staff B, U	conducted on 09/21/16 at 10:10 nit Manager and the Assistant a. The surveyor reviewed with						
	the staff regarding	the resident's stration. Concerns were						
	identified regarding		1					

PRINTED: 10/12/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 105492 09/22/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1626 DAVIS RD CONSULATE HEALTH CARE OF WEST PALM BEACH WEST PALM BEACH, FL 33406 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY F 309 Continued From page 13 F 309 prescription prescribes for the medication to be held on days and given after the resident returns from . The nurses documented that the medication was administered at 9:00 AM daily and not held on days as prescribed. The staff confirmed that the documentation indicated that the nurses did not follow the physician order for administration on , days. Furthermore regarding the order, the staff MAR however the noted the order on the nurses did not administer the 2:00 PM dose on days and the staff did not obtain clarification orders on how the medication was to be administered on these days to ensure the resident did not miss doses of medication to treat F 311 10/22/16 F 311 483.25(a)(2) TREATMENT/SERVICES TO SS=D IMPROVE/MAINTAIN ADLS

services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.

This REQUIREMENT is not met as evidenced

A resident is given the appropriate treatment and

by:
Based on observation, interviews and clinical
record review, the facility failed to offer and
provide assistance as needed for personal
hygiene as it related to oral care and shaving for
1 of 40 residents observed on Stage One
(Resident #16).

The findings included:

Multiple observations of Resident #16 revealed that the resident was unshaven and his mouth

potential to be affected by the same deficient practice and what corrective action will be taken:

Facility ID: 99032 | If continuation

What corrective action(s) will be

with his oral care and shaving.

How we will identify others having the

accomplished for those residents affected by the deficient practice?

Resident #16 was assisted immediately

If continuation sheet Page 14 of 43

		AND HUMAN SERVICES			PRINTED: 10/12/201 FORM APPROVEI DMB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	p y	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		105492	B. WING		09/22/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CONSUL	ATE HEALTH CARE	OF WEST PALM BEACH		1626 DAVIS RD WEST PALM BEACH, FL 33406	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIVE ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE COMPLETION
F 311	Continued From pa	ige 14	F3	111	
	contained a These observations AM the resident wa lying in bed. He we and / 09/20/16 at 9:44 AM in his wheelchair, the remained unshaver AM, the resident waying in bed, the resident with the contained on them. Interviews were conthe time of the about 11:37 AM, the resident waying in bed, the determined on them. Interviews were conthe time of the about 11:37 AM, the resident of the about 11:37 AM, the resident of the bed put the had not been protothpaste and had teeth. He further's up but did not shaw with the resident or	nd his teeth were not brushed is include: On 09/19/16 at 11:37 is observed to be dressed and as unshaven and had noted		Current residents who require ass with oral care and shaving could I been affected: observation was conducted none was identified by alleged deficient practice. What measures will be put into pl what systemic changes will be may ensure that the deficient practice recur: Nursing staff were in-serviced on and assisting residents with oral of shaving. Unit Manager/departme will check daily on residents to encare, shaving is provided and will findings to morning meeting. How the corrective action(s) will be monitored to ensure the deficient will not recur, i.e. what quality ass program will be put into place.	this ace or ade to does not offering are and in head sure oral report
	teeth this morning. not offer him oral h to brush his teeth.	He stated that the aide did rygiene products or set him up The resident also remains confirmed that the staff had not		DCS/designee will report finding t monthly until substantial compliar maintained.	
	The clinical record	for the resident documented	i		

An interview was conducted on 09/21/16 beginning at 12:22 PM with Staff D, the Certified Nursing Assistant (CNA). She stated she gave

Minimum Data Set Assessment

Facility ID: 95032

on the

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/12/2016 FORM APPROVED OMB NO. 0938-0391

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 105492 09/22/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1626 DAVIS RD CONSULATE HEALTH CARE OF WEST PALM BEACH WEST PALM BEACH, FL 33406 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATIONS CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 311 Continued From page 15 F 311 the resident a bed bath this morning but confirmed she did not shave the resident or assist the resident with oral care. She also confirmed she did not ask the resident about shaving and mouth care. The resident can brush his own teeth. She was assigned the resident for the past three days, Monday through Wednesday. She gave the resident a bed bath but she did not shave the resident or set him up for mouth care. She then stated that the resident will sometimes refuse but she admitted she did not ask the resident. F 325 483.25(i) MAINTAIN NUTRITION STATUS F 325 10/22/16 SS=D UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a

status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible, and (2) Receives a therapeutic diet when there is a nutritional problem.

(1) Maintains acceptable parameters of nutritional

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and record review the facility failed to provide the physician ordered diet for one of one resident reviewed for (Resident #65).

The findings included:

During an observation of the resident room

chips were removed immediately. Resident was re-educated on her

Facility ID: 95032

What corrective action(s) will be accomplished for those residents affected

Resident #65 glass of water, OJ, potato

diet and the potential risk if not followed.

by the deficient practice?

resident -

91

	TH AND HUMAN SERVICES RE & MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-03:
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
	105492	B. WING		09/22/2016
NAME OF PROVIDER OR SUPPLIE	ER .		STREET ADDRESS, CITY, STATE, ZIP CODE	
CONSULATE HEALTH CAR	F OF WEST PAI M BEACH	1	1626 DAVIS RD	
OUTOOD WE THENEDING OF BE			WEST PALM BEACH, FL 33406	
PREFIX (EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIC
F 325 Continued From	page 16	F 3	25	
conducted on 9// of ice water was speaks very little information as to the bedside table which is very hig A review of the c physician order f , idiet, a In an interview a acknowledged th been served the stated the reside own. On 9/21/16 at 8: breakfast tray re served instead c menu slip. Whet whether the resi juice (a very higil	20/16 at 2:52 PM, a 12 oz glass at the bedside. The resident who English, could offer no whether she requested it. On there was a bag of potato chips, h food. Ilinical record revealed a or food.		How we will identify others havir potential to be affected by the sideficient practice and what corruscition will be taken: Current residents with idlet have been affected by this alleg deficient practice. An audit was conducted to ensure residents diet do not receive OJ, potato cino at bedside, none was idit his alleged deficient practice. What measures will be put into what systemic changes will be resure that the deficient practic recur: Nursing and dietary staff were in on residents with idlet and CDM will monitor retray three times weekly to ensu accuracy. Nursing manager/department h	ame active could ed with initial with initial and hentified by place or made to e does not n-serviced sident's re
In an interview a agreed allowed on a for nutrition and	t 9:36 AM, the Registered that orange juice is not usually idlet. Review of the care plan hydration reveals identified focus all nutrition and fluid imbalances.		monitor resident's room daily to resident with has at bedside and diet order is folk Findings will be reported to mon meeting. How the correction action(s) will	s no owed. ming
Eurther review o	f the clinical record reveals		monitored to ensure the deficie	

laboratory values from the reflecting a high level of (5.8mg/dl) in the resident's in the month of

A review of the progress notes reveals an entry

dated ... "resident stated she would like to

maintained. Facility ID: 95032

will not recur, i.e. what quality assurance

DCS/designee will report findings to QAPI monthly until substantial compliance is

program will be put in place

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 105492 09/22/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1626 DAVIS RD CONSULATE HEALTH CARE OF WEST PALM BEACH WEST PALM BEACH, FL 33406 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID. (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY F 325 Continued From page 17 F 325 drink orange juice, was notified of dietary restrictions. Will honor preferences. Will care plan change." This note was signed by the Certified). In an interview Manager (conducted on 9/21/16 at 12:00 PM, the not aware of the resident's very high level in the and did not verbalize risks of high ... foods to the resident. Further review of the progress notes revealed dietary education as to risks, such as , from ingestion of high . foods for resident was not documented. F 332: 483.25(m)(1) FREE OF MEDICATION ERROR F 332 10/22/16 SS=E RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced Based on observation, interview and record What corrective action(s) will be review, it was determined that the medication rate accomplished for those residents affected was 10.7 percent. Three medication errors were by the deficient practice? identified while observing a total of 28 opportunities, affecting Resident # 124 and # 155. Resident #124 and #155 were assessed by nursing no negative outcome was identified. Medication error was done for The findings included: , family and MD were the 1) An observation of the medication notified. Medications reviewed by MD administration for Resident # 124 was conducted New order obtained. on 09/18/16 beginning at 9:44 AM with Staff A. Licensed Practical Nurse. The nurse prepared 11 How we will identify others having the potential to be affected by the same 5 mg one tablet; tablets (500 mg 2 deficient practice and what corrective 325 mg one tablet; action will be taken: 100 mg one tablet: capsules; MN ER 60 mg one tablet;

		AND HUMAN SERVICES				FORM	10/12/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
		105492	B. WING	_		09/	22/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CONSUL	ATE HEALTH CARE	OF WEST PALM BEACH			626 DAVIS RD VEST PALM BEACH, FL 33406		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 332	Continued From pa	ge 18	F 5	332			
	0.5 mg one tablet: tablet, 15 mg one Color MCR 50 mg one Color Upon verifying the Ithe surveyor inquire the cup as being a he did not have am investigation it was tablet was on the Cart. Closer inspecyielded that the bro	400 mg one tablet; pp. 25 mg one tablet; pp. 25 mg one tablet), number of tablets in the cup, da dabout one tablet noted in half tablet. The nurse stated half tablets. Upon further noted that the other half of the poor in front of the medication tion of the resident's pills ken tablet was the , also prepared 2 use top). e (,,,,	Current resident receiving medical including were reviewed none was identified alleged deficient practice. What measures will be put into pli what systemic changes will be mensure that the deficient practice recur: Nurses were in-serviced on proceimedication administration via and ADCS/designee will do med pass rurses two times weekly to ensure compliance. Findings will be reported to DCS. How the corrective action(s) will to monitored to ensure the deficient	d by this ace or ede to does not edure for with the edure practice	
	when administering At 10:11 AM, the n				will not recur, i.e. what quality ass program will be put into place.	surance	
	into the resident's The nurse padministration prod in the nurse did not have clear the	anc one erformed the same edure when administering the esident's The the resident her to before administering the he resident her did erriate did not have the to insure			DCS/designee will report findings monthly until substantial compliar maintained.	to QAPI	

The facility's policy and procedure regarding administration of medications included the

PRINTED: 10/12/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 105492 09/22/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1626 DAVIS RD CONSULATE HEALTH CARE OF WEST PALM BEACH WEST PALM BEACH, FL 33406 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 332 Continued From page 19 F 332 "Instruct resident to Resident should be sitting upright with tilted back slightly. with . Insert Occlude one tip into open Instruct resident to and squeeze once, quickly and firmly. Repeat if ordered. Then repeat on other side. Instruct the resident to keep tilted back for several minutes and slowly through b. The nurse failed to administer the correct medication and the number of prescribed. At 10:13 AM, the nurse administered in each one Upon reconciliation of the above medication administration with the current physician orders signed by the physician, the above medications

prescription for twice daily. The nurse instill in both of administered one On 09/22/16 at 9:08 AM an interview was conducted with Staff A. The surveyor reviewed with the nurse the medication administration. The nurse confirmed that he was unaware the pill broke in half until the surveyor brought it to his attention. He further confirmed that he did not follow the proper procedure for the administration and did not administer two of He used the and administered one each 2) A medication pass observation for Resident

were confirmed and noted a physician

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				FORM APPROVEI OMB NO. 0938-039				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION				E SURVEY	
	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD			CO	MPLETED	
		105492	B. WING				(00)0046	
NAME OF E	PROVIDER OR SUPPLIER	103452			REET ADDRESS, CITY, STATE, ZIP CODE	1 09	/22/2016	
					26 DAVIS RD			
CONSUL	ATE HEALTH CARE	OF WEST PALM BEACH			EST PALM BEACH, FL 33406			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(XS) COMPLETION DATE	
F 200	0 15	00						
F 332	Continued From pa	•	F	332				
1		ors. Staff C, an RN obtained the resident's						
	medications to incli							
	Review of the label	on the plastic bag that						
	contained the	was a sticker that						
	Wait 1 minute betw	ication has boxed warning: veen ; shake well before	1					
	using."	, straite well before						
1	administer the med resident on how to							
	administered the fit just 5 to 10 second dose.	rst dose of the , waited is and administered the second						
		v on 09/19/16 at 10:55 AM Staff t the time frame for						
		wo of the . The RN ould wait a minute between the agree that she failed to wait.						
	minute between OR according to m	mented, "Wait approximately 1 OR as ordered by physician nanufacturer's	:					
	recommendations. specific physician for administration of	"The record lacked any order related to the time frame of the doses."						
F 333 SS=E	483.25(m)(2) RES SIGNIFICANT ME	IDENTS FREE OF	F	333			10/22/16	
	The facility must early significant med	nsure that residents are free of dication errors.						
1	This DECLUDEME	NT is not met as evidenced						

by:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PRINTED: 10/12/2016 FORM APPROVED OMB NO. 0938-0391

(Y2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED 09/22/2016

105492

B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE 1626 DAVIS RD

CONSULATE HEALTH CARE OF WEST PALM BEACH

SUMMARY STATEMENT OF DEFICIENCIES

ID TAG WEST PALM BEACH, FL 33406

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG

PREFIX

F 333

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

Resident #65

(X5) COMPLETION DATE

F 333 Continued From page 21

NAME OF PROVIDER OR SUPPLIER

Based on clinical record review and staff interview, the facility staff failed to follow the physician orders for ... medication administration on multiple doses and medications prescribed to treat the resident's for 1 of 1 resident reviewed

(Resident #65). This is evidenced by the nurses failing to follow the physician orders for established parameters to administer or hold routine and/or as needed

medications; failed to administer medication prescribed three times daily for 4 days; failed to follow physician orders regarding medication on treatment days and failed to obtain clarification of medication to prescribed ensure the resident did not miss routine doses of

treatments

The findings included: The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included and

medication while at

The resident was scheduled to receive treatments in a community facility three days a week leaving the facility at 12:30 PM and returning after 5:00 PM on Monday, Wednesday and Friday. The following monthly physician orders were not followed to ensure the resident received and/or held the prescribed medications to treat her

, the physician prescribed for the resident to receive 0.1 mg by mouth

every 8 hours for greater Event ID: ILLV11 FORM CMS-2567(02-99) Previous Versions Obsolete

What corrective action(s) will be accomplished for those residents affected by the deficient practice?

physician order. Resident received meds : per . . , schedule. How we will identify others having the potential to be affected by the same deficient practice and what corrective

medication were reviewed by MD change was made per

action will be taken. Current residents receiving with order for parameters were audited to ensure compliance none was

identified by this alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not

Licensed staff was in-serviced on med error, following MD order with residents and narameters Unit Managers will review MAR twice weekly to ensure compliance. Findings

will be reported to DCS.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:

DCS/designee will report findings to QAPI monthly until substantial compliance maintained

when indicated:

recur:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OATE SURVEY COMPLETED	
		105492	B. WING			09/22/2016	
CONSULA	NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF WEST PALM BEACH (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			1626 DAVIS RD WEST PALM	SS, CITY, STATE, ZIP CODE BEACH, FL 33406 DVIDER'S PLAN OF CORRECT	1041	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	x (EACH	OFFICIENCY)	LD BE	(X5) COMPLETION DATE
:	documented the at administration time administration time administration time of 10:00 PM. There is medication entry to correscription prescription prescription prescription prescription prescription prescription in the physician order corresponding physician order corresponding physician order corresponding physician order corresponding physician order discontinuing the represcribing the as also did not docum appropriate boxes administered the physician didministration time 10:00 PM. Despite parameters associated the prescribed administration time 10:00 PM. Despite parameters associated the prescription of the produced prescription of the prescription of th	terstiman The stration Record (MAR) cove order and noted so of 9:00 AM, 6:00 PM and also a notation on the "see below re-written." The umented a physician bing for the resident to receive very 8 hours as needed for greater than Hold However further review of sold not document sician prescriptions outline and needed The MAR ent nurses initials in the to indicate that the nurses rescribed medication from 1/1. In ocumented an entry for the 0.1 every 8 hours and noted so of 6:00 AM, 2:00 PM and the medication having ated with the administration of e aren os specific inted for the administration of he facility noted.		333			
	On the 11-7 shift, they administered	he nurses documented that the > 28 times at 6:00					

AM however there were 27 legible

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	105492	B. WING		09/22/2016
NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF	OF WEST PALM BEACH		STREET ADDRESS, CITY, STATE 1626 DAVIS RD WEST PALM BEACH, FL 3	
PREFIX (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
doc prescribed paramet The 26 for 11-7 shift noted i ranged fro On the 3-11 shift, th documen documented the prescribed para their initials in the at the resident receive 10:00 PM. On the 7-3 shift, the documen prescribed paramet administration how that they administer 2:00 PM. 6 of those documented as beit Furthermore, the pf needed every 8 hou of administering the resident's The Me monitoring of the re shift. The nurses of 20 times, ranging fr nurses falled to ind	ted for this time period and 26 cumented failed to meet the ers of greater than for administration of the documented the resident's lend of the documented the documented the documented the documented the lend documented the documented the documented the medication 22 times at 22 times the resident was not at 2.00 PM. The documented the medication when the is greater than dictation MAR documented the sident's each occumented that the resident's each occumented that the resident's each occumented that the resident's were greater than were greater t		333	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X	(X3) DATE SURVEY COMPLETED	
		105492	B. WING		***************************************		09/22/2016	
	PROVIDER OR SUPPLIER	OF WEST PALM BEACH		1626	ET ADDRESS, CITY, STATE, ZIP COE DAVIS RD ST PALM BEACH, FL 33406	Œ		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BI		
F 333	resident to receive one tablet by mout days until after time of 9:00 AM. Administration Rec Metroprolol prescripaced their initials indicating the media to 9:00 AM with no that the medication for 6 of 8 time. In the medication of 6 of 8 times in the medication of 8 of 8 times in the medication at 9:00 There is no indicate the fore and resident returned a Am interview was a CAM with Staff C, R medications for the gives the 9:00 AM indicated. She will	7-3, 7-3, 7-3, 7-3, 7-3, 7-3, 7-3, 7-3,	F	3333				
	because her she needed to folk	had been but	İ					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		105492	B. WING		*******	05	9/22/2016
NAME OF PE	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
CONSTIL	TE UEALTH CARE	OF WEST PALM BEACH			DAVIS RD		
CONSULA	TE HEALIN CANE	OF THEST FACILIBEAGN		WES	ST PALM BEACH, FL 33406		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 333	Continued From pa	ige 25	F S	333			
F371	AM with Staff B. Ur Director of Nursing the staff regarding medication administ dientified regarding administ the medication to be given after the resistance of the staff regarding the staff regarding the noted the order on nurses documente administration on regarding the noted the order on nurses did not affollow the padministration on regarding the noted the order on nurses did not affollow the padministration or resident did not make the staff of the was a multiple occasions administered. Alse was administered. Alse was administered the resident's should have been	stration. Concerns were the resident's and ation. The and prescription prescribes for le held on days and dent returns from days and dent returns from The did that the medication was 10 AM daily and not held on season of the the thind that the nurses hysician order for days. Furthermore order, the staff the MAR however the hinister the 2:00 PM dose on he staff did not obtain on how the medication was to these days to ensure the se dose of medication to treat. Additionally on made as needed the resident's diding met the parameters on and the medication was not the routine dose of multiple times when based on reading held.		371			10/22/16
SS=F	The facility must - (1) Procure food fr	om sources approved or ctory by Federal, State or local					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

105492

OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING

PRINTED: 10/12/2016

FORM APPROVED

09/22/2016

NAME OF PROVIDER OR SUPPLIER

AND PLAN OF CORRECTION

CONSULATE HEALTH CARE OF WEST PALM BEACH

STREET ADDRESS, CITY, STATE, ZIP CODE 1626 DAVIS RD

WEST PALM BEACH, FL 33406 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION PREFIX REFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY

B. WING

F 371 Continued From page 26

authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions

F 371

This REQUIREMENT is not met as evidenced bv:

Based on observation and staff interview. the facility failed to ensure: equipment and utensils surfaces were clean and air dried, walls and floors were intact, smooth and cleanable, dumpster was free of holes, and staff washed hands during food preparation activities and during tray pass. This has the potential to affect all the residents who eat orally, 102 of 115 residents

The findings included:

During the initial tour of the kitchen conducted on 09/19/16 beginning at 8:55 AM and subsequent visits during the survey, accompanied by the Certified Dietary Managers (CDM) the following concerns were identified:

- 1) On 9/19/16 the surveyor observed small cracks, holding water and dirt in the surface of the floor in the dish room. There were also other cracks in the floor where the wall joins the floor in areas around the kitchen. The floor drain in front of the walk in refrigerator was obstructed with debris and uncovered
- 2) There was a section of the wall missing in the back of the kitchen adjacent to the storeroom entrance door. It was partially covered with a black colored board.

What corrective actions will be accomplished for those residents affected by the deficient practice:

- A) Cracks were sealed with silicone at time of survey, floor drain cleared of debris and covered at time of survey. B) Board was removed and ceramic tile installed at time of survey.
- C) The three ceramic tiles in the Janitor closet were replaced at time of survey. wet mop stored correctly at time of
- survey. D) Wall vent in the back of the kitchen was cleaned at the time of survey.
- E) Cutting boards were stacked correctly at the time of survey, new cutting boards ordered at the time of survey and was received
- F) Knife rack was cleaned at time of survev.
- G) Slotted spoons and spatula were ordered at the time of survey and received.

J) Nursing staff in-serviced on the

H) Dietary staff in-serviced on the importance of proper hand washing per policy with return demonstration. I) Waste Company notified of the need for new dumpster at the time of survey.

Event ID: II I V11

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		AND HUMAN SERVICES & MEDICAID SERVICES		PRINTED: 10/12 FORM APPRO OMB NO. 0938-	OVE	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	ILTIPLE CONSTRUCTION (X3) DATE SURVE	(X3) DATE SURVEY COMPLETED	
		105492	B. WING	USILITEO	16	
	PROVIDER OR SUPPLIER	OF WEST PALM BEACH		STREET ADDRESS, CITY, STATE, ZIP CODE 1626 DAVIS RD WEST PALM BEACH, FL 33406		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	(5) LETIO ATE	
F 371	Continued From pa	ige 27	F3	371		
	In the Janitor 0 missing on the wall directly on the floor	Closet there were three tiles and wet mop was stored		importance of proper hand washing during- meal delivery per policy with return demonstration.		
	in the clean utensil	dust and debris, rn cutting boards were placed area stacked so that moisture en them and not allowed to air	i	What corrective actions will be accomplished for those residents affected by the deficient practice?		
	dry. 6) The knife rack of the magnetic str 7) In the clean ute	had a film on dust on the top ip. ensil rack, several slotted		Current residents have the potential to be affected by the alleged deficient practice. Dietary rounds to be conducted three times per week to ensure compliance.		
	form areas to hold 8) During the obs service conducted 09/21/16, the AM of	tula had melted handles that food debris. ervation of the luncheon meal from 11:00 AM to 12:00 PM on ook performed many tasks sembling utensils, and setting		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?		
	up the trayline. Dur her hands and cha the trayline. 9) On 9/19/16 at	ring that time, she did not wash nge her gloves before starting 9:15 AM the surveyor		A) Dietary rounds to be conducted three times per week for any non-sealed cracks in the floor and broken or missing tiles or blocked drains. B) Dietary staff in-serviced on proper		
	CDMs. One of the were full of debris, lower edge on each	oster area accompanied by the two dumpsters, both of which had a line of holes along the h side where the metal had e CDM acknowledged the poor	i	storage of mops, cutting boards and melted handles on utensils as well as cleanliness of vents and knife rack. C) Observation of dumpster for holes		

washed her hands again for a total of 10 to 15 seconds. Staff K obtained the tray for the resident week.

three times per week.

D) Observation of dietary staff and nursing staff for proper hand washing by

Dietary Manager/ADCS two times per

Dietary Manager/designee will bring findings to the QAPI meeting until

substantial compliance maintained.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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09/22/2016

OMB NO. 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED A. BUILDING_

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B. WING _ 105492

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	100402		1 09/2	2/2010
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
CONSULATE HEALTH CARE OF WEST PALM BEACH			1626 DAVIS RD	
, 51100L	THE THE PERSON		WEST PALM BEACH, FL 33406	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 28	F3	371	
	Staff K failed to properly hand wash or sanitize between care for two different residents.			
	Review of the policy "Hand Washing Technique" dated 11/30/14 documented, "Rub hands together vigorously for 15 - 20 seconds, generating friction on all surfaces of the hands and fingers."			
	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	. F4	128	10/22/16
	The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.			
	The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.			
	This REQUIREMENT is not met as evidenced by:		What corrective action(s) will be	
	Based on clinical record reviews and staff interview, the facility physician failed to document the risk versus benefits when declining the pharmacy recommendations for 1 of 5 residents		accomplished for those residents affected by the deficient practice?	
	reviewed for pharmacy services (Resident #136). The findings included:		Resident #136 drug regimen was reviewed by MD, risk versus benefits was documented.	
	The monthly pharmacy reviews for Resident # 136 revealed that the consultant pharmacist on the Medication Regimen Review Report noted that "the resident is noted to be experiencing defined on a change of		How we will identify others having the potential to be affected by the same deficient practice and what corrective action will be taken:	
	condition medication regimen review request		Current residents pharmacy	

Event ID: ILLV11

PRINTED: 10/12/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 105492 09/22/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1626 DAVIS PD CONSULATE HEALTH CARE OF WEST PALM BEACH WEST PALM BEACH, FL 33406 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY F 428 : Continued From page 29 F 428 recommendations have been reviewed for completed by the facility. and 's use has been associated with appropriate response risk versus benefits The Consultant recommended that the documentation. physician evaluate the and What measures will be put into place or as contributing to this change in status, perhaps discontinuing its use. If this is to what systemic changes will be made to ensure that the deficient practices does continue, it is recommended that a) the prescriber document an assessment of risk versus benefit, not recur: indicating that the medication is not believed to be Attending physician will be in-serviced on contributing to the resident's change in condition; and b) the facility interdisciplinary team ensure proper documentation of the pharmacy recommendation. DCS will audit ongoing monitoring for effectiveness and potential adverse consequences (e. g. pharmacy recommendations for compliance. Physician's Response noted "I How the corrective action(s) will be decline the recommendation and do not wish to implement any changes due to the following monitored to ensure the deficient practice will not recur, i.e. what quality assurance reasons." However the physician did not document the rational or risk versus benefit. program will be put into place:

An interview was conducted on 09/22/16 at approximately 1:30 PM with the Director of Nursing, who confirmed the physician did not document the risk versus benefit for the continuation of the medications F 431 483.60(b), (d), (e) DRUG RECORDS

SS=E LABEL/STORE DRUGS & BIOLOGICALS

Review of the clinical record for Resident # 136

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically

did not provide evidence of this risk versus benefit being addressed in the record.

F 431

10/22/16

maintained

DCS/designee will report findings to QAPI

monthly until substantial compliance is

PRINTED: 10/12/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING B. WING 105492 09/22/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1626 DAVIS RD CONSULATE HEALTH CARE OF WEST PALM BEACH WEST PALM BEACH, FL 33406 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION IC (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRFFIX DATE REGULATORY OR LISC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 431: Continued From page 30 F 431 reconciled Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

by:
Based on observation, interview, record review
and policy review the facility failed to store
medications in 1 of 5 medication carts (the
medication cart on the odd side of the Friar Unit).
The nurse's practice and technique of closing the
medication cart resulted in the possibility for any
resident or visitor to obtain access to the
medications for 13 residents, during her worked
evening shifts. The facility failed to maintain an

accurate accounting of controlled substances for

This RECUIREMENT is not met as evidenced

What corrective action(s) will be accomplished for those residents affected by the deficient practice?

Med cart was locked immediately. 1:1 in-service was done with the nurse at the time of survey.

Resident #125 and #167 has an accurate

account of controlled substance, behavior monitoring sheets in place.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 105492 09/22/2016

NAME OF PROVIDER OR SUPPLIER

CONSULATE HEALTH CARE OF WEST PALM BEACH

2 of 5 random residents (Resident #125 and

were not left unattended for 1 of 4 residents

#167). The facility failed to ensure medications

STREET ADDRESS CITY STATE, ZIP CODE 1626 DAVIS RD

WEST PALM BEACH, FL 33406 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) IF ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG DATE TAG DEFICIENCY F 431 Continued From page 31

(Resident #124) observed during the medication pass observations.

The findings included:

1) During the medication pass observation on 09/20/16 at 5:12 PM Staff L, an RN (Registered Nurse) drew up for administration to the resident in . Upon returning to the medication cart, the RN carefully pulled out the locking mechanism with her fingers and proceeded to open the cart. The RN did not use any key; this medication cart had a locking mechanism to push in to lock, and to use a key to unlock. Staff L poured three additional pills for administration to the resident, and carefully and methodically, as if this was her practice, pushed in the locking mechanism part way. In doing this, the drawers were locked, but the locking mechanism could be pulled out by hand, not using a key, thus unlocking the medication cart and leaving medications for 13 residents available to anyone passing by. During the four-day survey, numerous family member were observed coming and going from this unit, as well as numerous residents independently moving throughout the building. One resident was observed wheeling himself independently through the unit, inspecting and playing with/moving all

During an interview immediately after the medication pass, Staff L would not admit that she purposely did not lock the cart, nor would she admit that it was her practice.

the door handles and locking mechanisms on the

F 431 Resident #124 medications are not left unattended.

> How we will identify others having the potential to be affected by the same deficient practice and what correction action will be taken:

Current residents have the potential to be affected by the alleged deficient practice. Audit of the controlled substance, flow sheet was behavior and conducted, none was identified by this alleged deficient practice.

How we will identify others having the potential to be affected by the same deficient practice and what corrective action will be taken: Licensed nurses were in-serviced on not

leaving medication unattended. Med cart to be completely locked at all times and documentation of controlled substances and flow sheet to be done properly. Unit manager will monitor behavior monitoring and flow sheet twice weekly and randomly check the med cart to ensure compliance. Will also monitor nurses during med pass to ensure meds are not left unattended; check the controlled substance sheet to ensure nurses sign the mars, I flow sheet and accordingly, findings will be reported to DCS weekly.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance

Facility ID: 95032

doors.

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from the

: (a

was removed from the in the medication cart on

at 10 PM both nights. Review of both the Behavior Symptom Monitoring Flow Record and MAR (Medication Administration Record) for 2016 lacked the documented administration of the medication on those dates. A second controlled substance record for Resident #167 documented the medication

for

or 2 tablets every 6 hours, as needed for This record documented one tablet was removed box in the medication cart on

/ at 9 AM. Review of both the

I/ - and

) 5-325 mg, to give 1

Flow 2016 lacked

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) MULTIPLE CONSTRUCTION A. BUILDING		(×	(X3) DATE SURVEY COMPLETED	
		105492	B. WING			09/22/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
CONEIL	ATE UEALTH CARE	OF WEST PALM BEACH	i	1626 DAVIS RD			
CONSUL	ATE HEALTH CARE	OF WEST FALM BEACH		WEST PALM BEACH, FL 33406			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		HOULD B		
E //31	Continued From pa	ngo 22	F 4	124			
1 431			F 4	131			
	the documented administration of the medication on that date.						
	substance records	side review of the controlled and the clinical records for #167, Staff J agreed with the					
	on 09/18/16 beginn Licensed Practical 11 tablets, 2 10:03 AM, the nurs room, the nurse pla resident's table and on the table while I the other side of th medications were I the direct vision of walked out of the r. the hallway twice a While the nurse let bedside, the reside containing the nurse returned, he placed the administ the table and agair wash his hands. A of and til also walked out of gloves from the minister walked out of gloves from the medical contents of the placed the administer table and agair wash his hands. A of	Resident # 124 was conducted ining at 9:44 AM with Staff A, Nurse. The nurse prepared and one and one and one are walked into the resident's saced all the medications on the the nurse left the medications on the effort on the overhed table out of the nurse. The nurse also oom to his medication cart in or retrieved a pair of gloves. The the medication cart in or retrieved a pair of gloves. The horize also own to his medication cart in or retrieved a pair of gloves. It the medications at the took the bag containing the resident. After administering and the pills, the nurse lettered bottle back on went into the bathroom to gain the nurse left the 2 bottles en the table. He the room again twice to obtain					

conducted with Staff A. The nurse confirmed he left the medications unattended and recalls the resident picking up the container for one of the

Event ID: ILLV11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED			
		105492	B. WING			09/22/2016		
NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF WEST PALM BEACH				STREET ADDRESS, CITY, STATE, ZIP CODE 1626 DAVIS RD WEST PALM BEACH, FL 33406				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE	
F 431	table.	age 34 e medications were left on the	F	131				
	Administration doc not leave medicati	umented "Facility staff should ons or chemicals unattended." N CONTROL, PREVENT	F	141			10/22/16	
	Infection Control P safe, sanitary and	stablish and maintain an lrogram designed to provide a comfortable environment and development and transmission action.						
	Program under wh (1) Investigates, co in the facility; (2) Decides what p should be applied	stablish an Infection Control						
	actions related to ib) Preventing Spr (1) When the Infect determines that a prevent the spread isolate the resider (2) The facility mu communicable dis from direct contact will (3) The facility mu hands after each in the spread in the sprea	infections. read of Infection stion Control Program resident needs isolation to d of infection, the facility must						

professional practice.

PRINTED: 10/12/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES. (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A RUILDING B. WING 105492 09/22/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1626 DAVIS RD CONSULATE HEALTH CARE OF WEST PALM BEACH WEST PALM BEACH, FL. 33406 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 441 Continued From page 35 F 441 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy What corrective action(s) will be accomplished for those residents affected review the facility failed to ensure 3 of 4 nurses (Staff A. C. H), observed during the medication by the deficient practice? pass observations properly hand washed or Resident #155, #87 and #124 were

(Residents #155, #87 and #124) . The findings included:

transmission of

1) A medication pass observation was made on 09/19/16 at 9:13 AM for Resident #155. Staff C. an RN (Registered Nurse) prepared 3 pills and for administration. After giving the pills and Staff C went into the bathroom of Resident #155 and washed her hands for a total

sanitized, to help prevent the development and

and practice affected 3 of 4 residents observed

This

of 5 to 10 seconds. 2) A medication pass observation was made on 09/20/16 at 4:22 PM for Resident #87. Staff H, an RN, gathered supplies on a disposable tray to). Staff obtain an H washed her hands in the resident's bathroom by applying soap and rubbing her hands together

soaping and rubbing her hands together for 4 to 5 seconds. Staff H gloved, cleaned the

for 6 seconds. Staff H gloved, obtained the , and washed her hands again by nurse/Unit Managers will observe hand washing during med pass twice weekly. How the corrective action(s) will be

monitored to ensure the deficient practice will not recur, i.e. what quality assurance

control

assess no adverse outcome identified.

How we will identify others having the potential to be affected by the same deficient practice and what corrective

Current resident have the potential to be

affected by the alleged deficient practice.

How we will identify others having the potential to be affected by the same

deficient practice and what corrective

Staff was in-service on proper hand washing per facility policy with return

action will be taken:

action will be taken:

demonstration.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDI	IPLE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		105492	B. WING		09/	22/2016
	PROVIDER OR SUPPLIE	E OF WEST PALM BEACH		STREET ADDRESS, CITY, STATE, ZIP O 1626 DAVIS RD WEST PALM BEACH, FL 33406		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFD TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 441	gloves and wash and immediately administration of did a final hand w just 5 seconds. During an intervit DON (Director of the hand washing are to wash their seconds. The DC hand hygiene pol the hand hygiene pol atted 11/30/14 d vigorously for 15 on all surfaces of a mount of the hand hygiene pol administration for on 09/18/16 begin Licensed Practic follow accepted a propropriately by washed hands a had applied the x at 10:04 AM, after the hand had had applied the x at 10:04 AM, after the hand had had applied the x at 10:04 AM, after the hand had had applied the x at 10:04 AM, after the hand had had applied the x at 10:04 AM, after the hand had had applied the x at 10:04 AM, after the hand had had had had applied the x at 10:04 AM, after the hand had had had had had had had had had ha	o obtain and the that bleach wipe., removed her ed her hands by applying soap rinsing. At 4:40 PM after the to Resident #87, Staff H vashing by applying friction for ew on 09/22/16 at 10:45 AM the Nursing) was made aware of g issues, and agreed the nurses hands for more than 5 - 10 NN was asked to provide the licy. Ido; "Hand Washing Technique" ocumented, "Rub hands together - 20 seconds, generating friction from the hands and fingers." In of the medication resident #124 was conducted inning at 9:44 AM with Staff A, all Nurse. The nurse failed to standards of practice for failing to perform hand hygiene hanges; failed to wash hands turning off the water with his just durning off the water with his just durning on the water after he soap and scrubbed his hands.	F4	program will be put into plate DCS/designee will report fir monthly until substantial comaintained.	ndings to QAPI	

washed hands. Upon retrieving another pair of

Facility ID: 95032

PRINTED: 10/12/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 105492 09/22/2016 STREET ADDRESS CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1626 DAVIS RD CONSULATE HEALTH CARE OF WEST PALM BEACH WEST PALM BEACH, FL 33406 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE ID REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 441 Continued From page 37 F 441 administered the to the resident. After administering the the nurse removed his gloves, the nurse retrieved another pair of gloves and donned the new pair of gloves. The nurse did not perform hand hygiene between glove changes. He then donned another pair of gloves and administered the second After removing his gloves, the nurse applied soap

with the nurse the hand hygiene observation during the medication administration. F 514 483.75(I)(1) RES SS=D RECORDS-COMPLETE/ACCURATE/ACCESSIB

> The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete: accurately documented; readily accessible; and

On 09/22/16 at 9:08 AM an interview was conducted with Staff A. The surveyor reviewed

to his hands. However the nurse did not turn on the water at this time. He then rubbed his hands together with the soap on his hands and used his soaped up left hand and turned on the water faucet to rinse his hands. He then obtained paper towels to dry his hands and to turn off the

F 514

10/22/16

and progress notes.

systematically organized.

water.

1 F

ED 91

		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: FORM. OMB NO.	APPROVE
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		SURVEY PLETED
		105492	B. WING		09/2	22/2016
NAME OF F	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE		
CONSUL	ATE HEALTH CARE	OF WEST PALM BEACH		1626 DAVIS RD WEST PALM BEACH, FL 33406		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE ([EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETIC DATE
F 514	Continued From pa	nge 38	F 5	14		
		NT is not met as evidenced				
	by:					
		ecord review and staff		What corrective action(s) will I		
		y staff failed to ensure the		accomplished for those resider	nts affected	
		oleteness of the medical		by the deficient practice?		
		residents whose records were		0 11 107 1 107		
	is evidenced by the	t#65, #127 and #217). This		Resident #67 has no negative 1:1 in-service provided to nurs		
		tained on the medication		regarding amending document		
		rd and not appropriately dating		Resident #127 clarification ord		
		ntation; failed to ensure as		obtained regarding		
		s were documented when			and type of	
		exceptions (meds not		were clarified in the me		
		appropriately circled and the		record.		
	reason the medica	tion was not administered was				
	documented on the	medication administration		How we will identify others hav		
		failed to ensure the		potential to be affected by the		
		e not contradictory but		deficient practice and what cor	rective	
		d the current physician orders		action will be taken		
		and failed to ensure the care				
	and services relate			Current residents with		
	were accurately do	cumented (Resident #217).		order and medication with parameters ha	ua tha	
	The findings include			potential to be affected by this		
	The indings includ	ed.		deficient practice.	anegea	
	1) Paview of the c	linical record for Resident # 65		Current resident's medical rec	ords were	
		roximately 2:30 PM the		reviewed to ensure compliance		
	Medica	tion Administration Record		found to be affected.		
		d two doses of as needed				
	0.1 mg c	oses were noted as		How we will identify others have		
		e back of the MAR. However	1	potential to be affected by the		
	upon receipt of the	copied MAR on 09/20/16, the		deficient practice and what cor	rective	

upon receipt of the copied MAR on 09/20/16, the back of the MAR documented 4 additional doses dated and Furthermore review of the same MAR on 09/21/16 at 3:00 PM again revealed 4

documentation and amending. Unit additional doses of as needed Manager will randomly check documented on the back of the MAR which were documentation twice weekly to ensure accuracy and compliance. Findings will not previously documented. The entries were

action will be taken:

Facility ID: 95032

Nurses were in-serviced on proper

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/12/2016 FORM APPROVED OMB NO. 0938-0391

OLNIER	O I ON WEDICARE	& WEDICAID SERVICES			UIVI	D NO. 055	0 0001
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	G	(X3) DATE SURVEY COMPLETED	
		105492	B. WING			09/22/2	016
	ROVIDER OR SUPPLIER	OF WEST PALM BEACH	10	TREET ADDRESS, CITY, STATE, ZIP CO 526 DAVIS RD /EST PALM BEACH, FL 33406	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD B		(X5) IPLETION DATE
F 514	MAR. A physicia resident to receive every 8 hours for than hold for than hold for administration time 10:00 PM. The MAR d PM dose, the nurse that the medication are days the reside However the back the 7 circled doses the reason the medication with the medication will be discussed in the medication on Resident #127 in bus on his back will elevated.	and a late entry notation on the an order prescribed for the 0.1 mg by mouth greater less than with so of 6:00 AM, 2:00 PM and ocumented 7 times at the 2:00 e icroled their initials indicating was not administered (, , , , , , , , , , , , , , , , , ,		be reported immediately to ID. How the corrective action(s) monitored to ensure the defi will not recur, i.e. what qualit program will be put into plac DCS/designee to report find to QAPI until substantial conmaintained.	will be cient pra y assura e ings mo	nthly	
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: ILLV11	Fa	cility ID: 95032 If o	continuatio	n sheet Page	e 40 of 43

DEDADTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/12/2016

		AND HUMAN SERVICES			FORM APPROVED
		& MEDICAID SERVICES			MB NO. 0938-0391
STATEMENT AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		105492	B. WING		09/22/2016
NAME OF P	ROVIDER OR SUPPLIER		•	EET ADDRESS, CITY, STATE, ZIP CODE	
CONSULA	ATE HEALTH CARE (OF WEST PALM BEACH	1	DAVIS RD ST PALM BEACH, FL 33406	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 514	Continued From pa	•	F 514		
	of (off at 10 AM - on a physician order she documented the or	t 2 PM). Review of this same let for 2016 der for at on 8 ?". The A or P for AM or			
	, and the fe	ional assessment dated ollow-up notes on cumented the	1		
	as on at 2 PM and off	at for ,	:		
	B, an RN and the U conflicting orders, s order for the	r on 09/21/16 at 9:32 AM, Staff Init Manager was shown the stated the current physician's was the n at 8 PM. The Unit Manager			
:	asked about the	M could not be correct. When order on the hysician order sheet, the Unit swer.			
	that the current ord , off at 10 AM	was present during the Unit Manager, confirmed the was for for land on at 2 PM, and that the was not taken off the			
		OS (physician order sheet). e record documented			
	revealed Resident to the	ne left that was present			
	care physician's pr	s documented on the ogress note dated een admitted on Friday			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/12/2016

		AND HUMAN SERVICES					KM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	O. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		ONSTRUCTION		ATE SURVEY OMPLETED
		105492	B. WING				9/22/2016
NAME OF F	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
CONSUL	ATE HEALTH CARE	OF WEST PALM BEACH			DAVIS RD ST PALM BEACH, FL 33406		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 514	Continued From pa	ige 41	F	514			
	Resident #217 stat from a , as she . Resident #217 the of her right a new of resident stated that that since it had to her to that Review of the reco admitted to the fac diagnosis of a documentation as Review of the initia documen	on her further stated the to the started last from ordered by her take has had treatments to that time. She stated that she right to improve rid revealed Resident #217 was with a the first has had the first had the right to improve the revealed Resident #217 was with a the right for the record lacked the right had the righ					
	documented the or device that applies) to the left Thursdays and Sa (Treatment Admini 2016 revealed the on Saturday blank box where the should be. Review	to enhance on Tuesdays, turdays. Review of the TAR stration Record) for	i				
	During an interview Staff P, the RN wh #217 confirmed th	w on 09/21/16 at 10:32 AM, to normally cares for Resident has always been					

Facility ID: 95032

PRINTED: 10/12/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 105492 09/22/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1626 DAVIS RD CONSULATE HEALTH CARE OF WEST PALM BEACH WEST PALM BEACH, FL 33406 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 514 Continued From page 42 F 514 During an interview on 09/21/16 at 11:45 AM the DON was asked about the initial order for the to the left , and where that order came from. The DON was unable to locate any documentation, and stated it sometimes comes from report from the hospital. The DON stated that admissions made sure the was here prior to the resident arriving. The DON also found documentation in the record that the I to the right was a During an interview on 09/22/16 at 11:49 AM Staff I, the LPN (Licensed Practical Nurse) who cared for Resident #217 during the day on when the was due to be applied to the , stated the wasn't at the facility, so their protocol is to do a wet to dry . She further stated that the supervisor was going to do the Staff I was

FORM CMS-2567(02-99) Previous Versions Obsolete

#217.

asked to locate and provide any documented

on

During an interview on 09/22/16 at 1:12 PM the DON provided documentation that the supplies had not arrived at the facility on , and agreed that the sequence of events at the time of admission to the facility, and during the first weekend at the facility was not thoroughly documented in the record for Resident

care to the

unable to find any.

, and she was

A	Linalth Care Ada	[_]			FORM A	PPROVED
Agency for Health Care Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 95032		A. BUILDING:	E CONSTRUCTION	(X3) DATE S COMPL		
		95032	B. WING		09/22	/2016
NAME OF PR	OVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
CONSULA	TE HEALTH CARE	DE WEST PAIM F	AVIS RD PALM BEACH,	FL 33406		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
N 000 II	NITIAL COMMEN	rs	N 000			
C L	onducted on 09/19 Consulate Healthca	telicensure survey was 9/2016 through 09/22/2016 a are of West Palm Beach, 1. The facility had deficiencid f the visit.				
SS=E	All physician orders prescribed, and if r	Follow Physician Orders s must be followed as tot followed, the reason must resident 's medical record	N 054			10/22/16
	Based on administ eview and staff int of follow the physic medication administ medications prescribed for for Resident #65). Til alliling to follow the stabilished param outline and/or as medications; failed medication prescribed alays, failed to follome the stabilished param outline and/or as medications; failed medication prescribed to follome the stabilished param outline and failed to follome the stabilished param of the stabilished param	stration on multiple doses an ibed to treat the resident's 1 of 1 patient review his is evidenced by the nurse physician orders for eters to administer or hold leeded	d d ed s	Preparation and submission of thi correction does not constitute an admission or agreement by the pr the truth of the facts alleged or the correctness of the conclusions se the statement of deficiencies. The correction is prepared and submit solely because of the requirement State and Federal law. This plan of correction will serve a Facility's allegation of substantial compliance. What corrective actions will be accomplished for those residents by the deficient practice?	ovider of e t forth on e plan of ted ts under	
		acility also failed to followed to 2 of 4 residents observed	he	Resident #65 was reassessed;	meds	

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE
Electronically Signed

TITLE (X6) DATE 10/11/16

Agency for Health Care Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION WITH PROVIDER SUPPLIER CLIA IDENTIFICATION NUMBER: 95032 STREET ADDRESS, CITY, STATE, ZIP CODE 1626 DAVIS RD WEST PALM BEACH, FL. 33406 WEST PALM BEACH, FL. 33406 WEST PALM BEACH, FL. 33406 SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) N 054 Continued From page 1 during medication administration (Residents # 124 and # 155). The findings included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included WEST PALM BEACH. FL. 33406 WEST PALM BEACH, FL. 33406 WEST PALM BEACH, FL. 34406
AND PLAN OF CORRECTION DENTIFICATION NUMBER: 95032 B. WING 95032 B. WING DISPLAYED 09/22/2016 SURPLETED 0
Page 2 Provider or supplier STREET ADDRESS, CITY, STATE, ZIP CODE
NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF WEST PALM E 1926 DAVIS RD WEST PALM BEACH, FL 33406 WEST PALM BEACH, FL 33406 SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) N 054 Continued From page 1 during medication administration (Residents # 124 and # 155). The findings included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included
NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF WEST PALM E 1928 DAVIS RD WEST PALM BEACH, FL 33406 WEST PALM BEACH, FL 33406 SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) N 054 Continued From page 1 during medication administration (Residents # 124 and #155). The findings included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on medication in reviewed by MD, new order obtained.
CONSULATE HEALTH CARE OF WEST PALME CALLID SUMMARY STATEMENT OF DEFICIENCIES DESTRUCTION
CONSULATE HEALTH CARE OF WEST PALME CALLID SUMMARY STATEMENT OF DEFICIENCIES DESTRUCTION
CONSULATE HEALTH CARE OF WEST PALM WEST PALM BEACH, FL 33406 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) N 054 Continued From page 1 N 054 during medication administration (Residents # 124 and # 155). The findings included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on meaning the record of th
REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION The findings included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included REGULATORY OR LSC IDENTIFY INFORMATION 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included REGULATORY OR LSC IDENTIFY INFORMATION REGULATORY O
REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION The findings included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included REGULATORY OR LSC IDENTIFY INFORMATION 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included REGULATORY OR LSC IDENTIFY INFORMATION REGULATORY O
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) N 054 Continued From page 1 during medication administration (Residents # 124 and # 155). The findings included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included: n 054 Continued From page 1 were reviewed to ensure administration before or after per doctor's order. Resident #124 and #155 were assessed by nursing, no negative outcome was identified. Medication error was done for the family and MD were notified. Medications reviewed by MD, new order obtained.
N 054 Continued From page 1 during medication administration (Residents # 124 and # 155). The findings included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included: N 054 were reviewed to ensure administration before or after per doctor's order. Resident #124 and #155 were assessed by nursing, no negative outcome was identified. Medication error was done for the family and MD were notified. Medications reviewed by MD, new order obtained.
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before or after per doctor's order. Resident #124 and #155 were assessed by nursing, no negative outcome was identified. Medication error was done for the finding and MD were notified. Medications reviewed by MD, new order obtained.
The findings included: The findings included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included Resident #124 and #155 were assessed by nursing, no negative outcome was identified. Medication error was done for the family and MD were notified. Medications reviewed by MD, new order obtained.
The findings included: 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included 1. The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included new order obtained.
The clinical record for Resident #65 disclosed that the resident was readmitted to the facility on with diagnoses which included identified. Medication error was done for the family and MD were notified. Medications reviewed by MD, new order obtained.
The clinical record for Resident # 65 disclosed that the resident was readmitted to the facility on with diagnoses which included new order obtained. **The clinical record for Resident # 65 disclosed the family and MD were notified. Medications reviewed by MD, new order obtained.
that the resident was readmitted to the facility on with diagnoses which included notified. Medications reviewed by MD, new order obtained.
with diagnoses which included new order obtained.
and
The resident was scheduled to receive How we will identify others having the
treatments in a community potential to be affected by the same
facility three days a week leaving the facility at deficient practice and what corrective
12:30 PM and returning after 5:00 PM on action will be taken:
Monday, Wednesday and Friday. The following
monthly physician orders were not followed to Current residents receiving with
ensure the resident received and/or held the medications were reviewed, none was
prescribed medications to treat her identified by this alleged deficient practice.
pressure when indicated: Current resident receiving medication
including
A. On the physician prescribed for the were reviewed, none was identified for this
resident to receive 0.1 mg by mouth alleged deficient practice.
every 8 hours for greater
than Hold for less than The
Medication Administration Record (MAR) What measures will be put into place or
documented the above order and noted what system changes will be made to
administration times of 9:00 AM, 6:00 PM and ensure that the alleged deficient practice
10:00 PM. There is also a notation on the does not recur:
medication entry to "see below re-written." The
notation below documented a physician Nursing staff were educated on following prescription prescribing for the resident to receive doctor's order of residents. Unit
notation below documented a physician Nursing staff were educated on following prescription prescribing for the resident to receive doctor's order of residents. Unit
notation below documented a physician prescription prescribing for the resident to receive occurs of the control of the resident to receive occurs of the control of the co
notation below documented a physician prescription prescribing for the resident to receive 0.1 mg every 8 hours as needed for greater than Hold ensure accuracy.
notation below documented a physician prescription prescribing for the resident to receive 0.1 mg every 8 hours as needed for greater than Hold for less than However further review of
notation below documented a physician prescription prescribing for the resident to receive 0.1 mg every 8 hours as needed for greater than Hold ensure accuracy.

. The MAR

administered the prescribed medication from AHCA Form 3020-0001
STATE FORM

prescribing the as needed

also did not document nurses ' initials in the

appropriate boxes to indicate that the nurses

nurses two times weekly to ensure

Findings will be reported to DCS.

compliance.

Agency for Health Care Adm	inistration			PRINTED: 10/12/2016 FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95032	B. WING		09/22/2016
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE	
CONSULATE HEALTH CARE	OF WEST PALM E 1626 DAV WEST PA	IS RD LM BEACH,	FL 33406	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
N 054 Continued From pa	ge 2	N 054		
prescribed administration time 10:00 PM. Despite parameters associate the the there document the medication. The for the the multiple doses of the administered when did not multiple the search of the the theory of the the theory of the theo	ocumented an entry for the 0.1 every 8 hours and noted s of 6.00 AM, 2:00 PM and the medication having sted with the administration of a zer no specific inted for the administration of e facility noted research the corresponding let where the corresponding eet the prescribed parameters ed their initials in the loindicate the medication was the nurses documented that 28 times at 6:00 were 27 legible inted for this time period and 26 commented failed to meet the ters of greater than for administration of the documented the resident's on to did not meet meters yet the nurses placed ameters yet the nurses placed suppropriate boxes to indicate		How the corrective action(s) will b monitored to ensure the deficient will not recur, i.e. what quality ass program will be put into place. DCS/designee will report findings monthly until substantial complian maintained.	practice urance to QAPI

On the 7-3 shift, there were 27 legible documented, 24 did not meet the

					FORM APPROVED	
STATEMEN	for Health Care Adm of OF DEFICIENCIES OF CORRECTION	inistration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		95032	B. WING		09/22/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET	ODRESS, CITY, S	TATE, ZIP CODE		
CONSUL	ATE HEALTH CARE	OF WEST PALM E 1626 DA	IVIS RD ALM BEACH, F	FL 33406		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETE	
N 054	Continued From pa	ge 3	N 054			
	that they administe 2:00 PM, 6 of those documented as bei Furthermore, the p needed every 8 ho of administering the resident's The Me monitoring of the resident's The nurses called to ind was administered the exceeded times, ranging f nurses failed to ind was administered to the control of the resident to receive one tablet by mout days until after time of 9:00 AM. Administration Red Metroprolog prescriplaced their initias indicating the med at 9:00 AM with no that the medication that the medication.	hysician prescribed on 0.1 mg to be administered as urs with the stated parameter a medication MAR documented the sident's each tocumented that the resident's were greater than rom to However the icate the as needed when the resident's the prescribed parameters 1 1, 7-3, 7-3, 3-11, 3-11, ician order prescribed for the 50 mg gih tonce daily. Hold on on MWF. Administration The Medication ord (MAR) documented the pition and noted the nurses in the appropriate boxes cation was administered daily.	e e s o o o o o o o o o o o o o o o o o			

_____in ____and AHCA Form 3020-0001 STATE FORM

on

Agency for Health Care Adm	inintration			PRINTED: 10/12/2016 FORM APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	95032	B. WING		09/22/2016	
NAME OF PROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, S	STATE, ZIP CODE		
CONSULATE HEALTH CARE O	OF WEST PALM E WEST PA	VIS RD ALM BEACH,	FL 33406		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETE	
N 054 Continued From pa	ge 4	N 054			
The nurses placed boxes indicating the medication at 9:00. There is no indicatible before and resident returned at An interview was co. AM with Staff C. Re medications for the gives the 9:00 AM rindicated. She will remembers the give the resident the because her she needed to follow the resident the because her she needed to follow the staff regarding the staff regarding identified regarding administrate the medication to be given after the resident was compared to the medication of the medica	AM including days on the medication was held administered when the prescribed. Onducted on 09/21/16 at 9:25 gistered Nurse, regarding resident. She stated she medications to the resident as hold the but she center asking for them to enter asking for them to emedication but when the second of the resident's and the second of the second				
that the documenta did not follow the pl	scribed. The staff confirmed tion indicated that the nurses				

regarding the order on the nurses did not administer the 2:00 PM dose on days and the staff did not obtain AHCA Form 3020-0001

Δαρου	for Health Care Adm	inistration					D: 10/12/2016 I APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY IPLETED		
		95032		B. WING		09/	22/2016
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
CONSUL	ATE HEALTH CARE	OF WEST PALM E	1626 DAV	IS RD LM BEACH,	FL 33406		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
N 054	Continued From pa	ge 5		N 054			
	clarification orders be administered on resident did not mis her, the resident's parameters on multiple times when their did not missed to the control of the control o	these days to ensus doses of medication Additionally, owas made as not reading met tiple occasions and administered. Also was administ	re the ion to treat in leeded the the the o the ered dent's				
	on beginn Licensed Practical tablets (325 mg one capsules; 0.5 mg one tablet, tablet, 1 GM MCR 50 mg one cablet, tubor verifying the the surveyor inquire the cup as being a he did not have any investigation it was tablet was on the fic cart. Closer inspec yielded that the bro 100 mg. The nurse	tesident # 124 was, sing at 9:44 AM with Nurse. The nurse p 5 mg one tablet; tablet; 500, 100 mg one tablet one tablet; 25 mg one tablet; p; 25 mg one number of tablets in del about one tablet; half tablets. Upon noted that the other on the front of the m tion of the resident; ken tablet was the also prepared 2 ue top);	Staff A, prepared 11 0 mg 2 t; 00 mg one e tablet), the cup, noted in se stated further r half of the edication				

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The following errors were also noted regarding the medication administration:

FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 95032 B. WING _ 09/22/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1626 DAVIS RD CONSULATE HEALTH CARE OF WEST PALM F WEST PALM BEACH, FL 33406 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) N 054 Continued From page 6 N 054 a. The nurse failed to use the proper technique when administering the At 10:11 AM, the nurse shook the bottle of multiple times and inserted the into the resident's and one The nurse performed the same administration procedure when administering the in the resident's The nurse did not have the resident her clear the before administering the have the resident tilt her : did not occlude the alternate did not have the resident the to insure penetration of the medication before into the other administering the The facility's policy and procedure regarding administration of medications included the following procedure for "Instruct resident to Resident should be sitting upright with head tilted back slightly. Occlude one with _ : Insert tip into open Instruct resident to and squeeze once, quickly and firmly. Repeat if ordered. Then repeat on other side. Instruct the resident to keep tilted back for slowly through several minutes and b. The nurse failed to administer the correct medication and the number of prescribed.

signed by the physician, the above medications AHCA Form 3020-0001

At 10:13 AM, the nurse administered in each

Upon reconciliation of the above medication administration with the current physician orders

one

A for the life Co-	. A desta	talandan			FORM APPROVED	
Agency for Health Care STATEMENT OF DEFICIENCI AND PLAN OF CORRECTION	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		95032	B. WING		09/22/2016	
NAME OF PROVIDER OR SUI	PLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
CONSULATE HEALTH O	ARE OF	WEST PALM E 1626 DAV	'IS RD LM BEACH, I	FL 33406		
PREFIX (EACH DEF	ICIENCY N	MENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE	
N 054 Continued Fr	om pag	e 7	N 054			
were confirm prescription of instill 2 administered On 09/22/16 conducted will with the nursh nurse confirm broke in half attention. He follow the production of each 3. A medicati #155 was ma AM with two (Registered I medications Review of the contained this contained the documented	ed and in portion in both one at 9:08 at 19:08 a	twice daily. The nurse of twice daily. The nurse of the same of th				
using."	ed the r	oom of Resident #155 to				
administer th resident on h administered	e medio low to the firs	cations. Staff C instructed the the medication. Staff C	1			
During an int	erview o	on 09/19/16 at 10:55 AM Staf	f _t			

doses, but did not agree that she failed to wait. AHCA Form 3020-0001

C was asked about the time frame for administering the two of the agreed that she should wait a minute between the

Agency f	or Health Care Adm	inistration		Р	FORM APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:		(X3) DATE SURVEY COMPLETED
		95032	B. WING	anneres .	09/22/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
CONSUL	ATE HEALTH CARE	OF WEST PALM E 1626 DAV WEST PA	IS RD LM BEACH,	FL 33406	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
N 054	Continued From pa	ge 8	N 054		
	minute between OR according to m recommendations.	nented, "Wait approximately 1 OR as ordered by physician anufacturer's The record lacked any order related to the time frame			
N 093 SS=E	The pharmacist share in order and the	Controlled Drug - Accounting all determine that drug records at an account of all controlled d and periodically reconciled.	N 093		10/22/16
	This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to maintain an accurate accounting of controlled substances for 2 (Resident #125 and #167) of 5 random residents.		Transfer to	What corrective action(s) will be accomplished for those residents a by the deficient practice? Resident #125 and #167 has an accomplished with the second will be accomplished for those residents and the second will be accomplished for those residents as a second will be accomplished for those residents as a second will be accomplished for those residents as a second will be accomplished for those residents as a second will be accomplished for those residents as a second will be accomplished for those residents as a second will be accomplished for those residents as a second will be accomplished for those residents as a second will be accomplished for those residents as a second will be accomplished for the second will be accomplished will be accomplished for the second will be accomplished for the seco	ccurate
	Unit 09/22/1 Staff J, an LPN (Li random check of the for Resident #125 (a me (milligrams) to be	the medication cart for the 6 at 1:43 PM was made with censed Practical Nurse). A be controlled substance record documented the medication dication for 15 pt medication in the controlled with the medication for 15 pt me	· coadeacti.	account of controlled substance, be monitoring sheets in place. How we will identify others having i potential to be affected by the alleg deficient practice. Audit of the controlled substance, I and flow sheet was conducted wad identified by this alleged deficipractice.	the ged behavior d, none
	in the medication of at 10 PM both night Behavior Symptom MAR (Medication)			What corrective action will be take correct the alleged deficient practic Licensed nurses were in-service o	ce:

Agency for Health Care Adm	injetration			FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95032	B. WING		09/22/2016
NAME OF PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE	
CONSULATE HEALTH CARE	OF WEST PALM E 1626 DAV	S RD LM BEACH.	FL 33406	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER (CROSS-REFERENCED TO THE APPROVIDER (CROSS-REFERENCE))	D BE COMPLETE
N 093 Continued From pa	ge 9	N 093		
administration of the A second controlled Resident #167 doc (a or 2 tablets every 6 This record document from the b life of the ABA Sheet and the MAR the documented ac on that date. During this side by substance records	e medication on those dates. I substance record for umented the medication for) 5-325 mg, to give 1 hours, as needed for ented one tablet was removed to in the medication cart on eview of both the Flow		documentation of controlled substand flow sheet to be done pro Unit manager will monitor behavior monitoring and flow sheet twi weekly to ensure compliance. Will also monitor nurses during mto ensure nurses sign the mar, sheet and BMS accordingly. Findings will be reported to DCS v. How the corrective action(s) will be monitored to ensure the alleged of practice will not recur, i.e. what quassurance program will be put into DCS/designee will report finding to monthly until substantial complian maintained.	operly. r ce ed pass flow veekly. e efficient alidity a) place. b CAPI
SS=D Medical Records 400.141(1)(j) FS Keep full records of discharges; medical including medical ristory, and identity other persons who affairs of the reside care plans, including prescribed service duration, and service duration, and service accordance with a and practices, which is the service of the service duration and service of the service duration, and service duration, and service duration, and prescribed service duration, and prescribes, which is the service of the service duration and practices, which is the service of the service duration and practices, which is the service of the service duration and practices, which is the service of the servi	f resident admissions and all and general health status, ecords, personal and social and adverses of next of kin or may have responsibility for the int, and individual resident rg, but not limited to, service frequency and ce goals. The records must be pection. The licensee shall cords on each resident in ocepted professional standards himust be complete, mited, readily accessible, and initized.	N 101		10/22/16

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Agency for Health Care Adm	inistration			FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95032	B. WING		09/22/2016
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
CONSULATE HEALTH CARE	OF WEST PALM F WEST PA	IS RD LM BEACH,		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROID DEFICIENCY)	D BE COMPLETE
N 101 Continued From pa	ige 10	N 101		
information to clea her diagnosis and This Statute or Rul Based on clinical in interview, the facilitical couracy and com records for 3 of 19 reviewed (Residen is evidenced by the documentation cor administration rect the added documeneded medication administered and administered and courmented on the record. The facility orders we accurately reflecte (Resident # 127); and services relatit were accurately do The findings included the property of the control of the co	ntained on the medication of and not appropriately dating ntation; failed to ensure as is were documented when exceptions (meds not a appropriately circled and the tion was not administered was e medication administration of failed to ensure the e not contradictory but d the current physician orders and failed to ensure the care ed to the resident's ccumented (Resident #217).	the control of the co	What corrective action(s) will be accomplished for those residents by the deficient practice? Resident #65 has no negative out 1:1 in-service provided to nurse id regarding amending documentatic Resident #127 clarification order obtained regarding Resident #217 location are were clarified in the medic record. How we will identify others having optential to be affected by the san deficient practice and what correct action will be taken. Current residents with order and medication with parameters have potential to be affected by this alledeficient practice. Current residents medical record recorder resident's medical record recorder the side of the same compliance; of found to be affected.	come. tentified on. was ditype of al the me the egged is were

and AHCA Form 3020-0001

of as needed

0.1 mg doses were noted as administered on the back of the MAR. However, upon receipt of the copied MAR on 09/20/16, the

back of the MAR documented 4 additional doses

dated . Furthermore, review of the same How we will identify others having the potential to be affected by the same

deficient practice and what corrective action will be taken:

Nurses were in-serviced on proper

				FORM APPROVED
Agency for Health Care Admi				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95032	B. WING		09/22/2016
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS CITY 5	STATE, ZIP CODE	
NAME OF PROVIDER OR SOFFEIER	1626 DAV			
CONSULATE HEALTH CARE O	NE WEST PALM F	LM BEACH,	FL 33406	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE COMPLETE
N 101 Continued From pa	ge 11	N 101		1
MAR on 09/21/16 a additional doses of documented on the not previously docu dated and did not indicate MAR. A physicia resident to receive every 8 hours for than hold for administration time 10:00 PM. The MAR d PM dose, the nurs that the medication are days the reside However the back the 7 circled doses the reason the met "	13:00 PM again revealed 4 as needed back of the MAR which were mented. The entries were i and a late entry notation on the an order prescribed for the 0.1 mg by mouth greater with so fo:00 AM, 2:00 PM and occumented 7 times at the 2:00 ericled their initials indicating was not administered (, , , , , , , , , , , , , , , , , ,		documentation and amending. Ut Manager will randomly check documentation twice weekly to en accuracy and compliance. Finding be reported immediately to DCS. How the corrective action(s) will be monitored to ensure the deficient will not recur, i.e. what quality ass program will be put into place. DCS/designee to report findings in QAPI until substantial complian maintained.	sure gs will e practice urance

at . The resident was on his back with the head of the bed elevated.

Review of the record revealed Resident #127 was

FORM APPROVED Agency for Health Care Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 09/22/2016 95032 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1626 DAVIS RD CONSULATE HEALTH CARE OF WEST PALM E WEST PALM BEACH, FL 33406 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG DEFICIENCY) N 101 N 101 Continued From page 12 admitted to the facility on with a . Review of the current re-admission on physician order sheet for 2016 documented the order dated for the of (off at 10 AM - on at 2 PM). Review of this same 2016 physician order sheet for documented the order for at "off at 10 A - on 8 ?". The A or P for AM or PM was not legible. Review of the nutritional assessment dated , and the follow-up notes on all documented the and for 20 hours. as at on at 2 PM and off at 10 AM. During an interview on 09/21/16 at 9:32 AM, Staff B, an RN and the Unit Manager was shown the conflicting orders, stated the current physician's was the order for the off at 10 AM and on at 8 PM. The Unit Manager agreed that the 8 PM could not be correct. When asked about the order on the 2016 physician order sheet, the Unit : Manager did not answer. was present during the interview with the Unit Manager, confirmed for 20 that the current order was for hours, off at 10 AM and on at 2 PM, and that the order was not taken off the 2016 POS (physician order sheet). The agreed the record documented

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conflicting orders.

revealed Resident #217 had an to the left

upon admission, as documented on the

3) Review of the record on 09/20/16 at 10:24 AM

that was present

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STATEMEN	for Health Care Adm it of DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NO		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		95032		B. WING		09/22/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
CONSUL	ATE HEALTH CARE	OF WEST PALM E	1626 DAV WEST PA	IS RD LM BEACH,	FL 33406	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCE MUST BE PRECEDED BY SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
N 101	Continued From pa	ge 13		N 101		
	care physician's pro The resident had be Resident #217 stat from a as she. Resident #217 the of her right a new of resident stated that that since thad to her to that	or o	of PM was on her to from The lents to that she was a coord lacked at the left device to (a o enhance lays, he TAR d to the left do by the	and the second s		
	should be. Review	e nurse's initials for of the Daily Skilled acked any documer	Nurse's	- Company		

During an interview on 09/21/16 at 10:32 AM, Staff P, the RN who normally cares for Resident #217 confirmed the has always been AHCA Form 3020-0001

Agency f	or Health Care Adm	inistration				FORM APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		95032		B. WING		09/22/2016
NAME OF F	ROVIDER OR SUPPLIER		STREET ADD	ORESS, CITY, S	TATE, ZIP CODE	
CONSUL	ATE HEALTH CARE	OF WEST PALM E	1626 DAVI WEST PAI	S RD LM BEACH, I	FL 33406	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETE
N 101	Continued From pa	ge 14		N 101		
	for the right no	ot the left				
	DON was asked at to the I came from. The DC documentation, and from report from the that admissions maprior to the residen documentation in the right was a During an interview. Staff I, the LPN (Lic cared for Resident is, when the applied to the staffly, so their prosecutions of the staffly so the staffly so their prosecutions of the staffly so the sta	DN was unable to loc. of a stated it sometimes to hospital. The DON add sure the was a tarriving. The DON and record that the properties of the properties o	or the hat order atte any comes stated is here iso found to the AM, see) who one to be tat the dry vervisor I was			
	DON provided doc supplies had and agre at the time of admi the first weekend a	y on 09/22/16 at 1:12 umentation that the not arrived at the facilitied that the sequence ssion to the facility, a tit the facility, was not ented in the record for	lity on of events nd during	in the state of th		
	Class III			5		

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N 201 400.022(1)(I), FS Right to Adequate and SS=E Appropriate Health Care

N 201

10/22/16

	f C A-				FORM APPROVED
STATEMEN	for Health Care Adm IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		95032	B. WING		09/22/2016
	PROVIDER OR SUPPLIER	DE WEST DALME 1626 DAV		STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE COMPLETE
N 201	health care and priculating social serial valiable, planne therapeutic and relief with the resident or recognized practice community, and with agency. This Statute or Rull Based on observar veview the facility fraccordance with the and interest of the #217) of 3 resident hand interest of the residents who wer facility failed to ensuadministered before effectiveness for 1 reviewed for to provide assistant to oral care and shall be residents observations. The findings included the foods and the foods and the findings included the foods and the	a adequate and appropriate telective and support services, cives, mental health services, of recreational activities; and abilitative services consistent re plan, with established and standards within the th rules as adopted by the e is not met as evidenced by: ion, interview and record alled to provide activities in ecomprehensive assessment seidents, for 1 (Resident s reviewed, of a sample of 17 able to be interviewed. The ure medications were e and after for optimal (Residnet #65) of 1 resident treatments. The facility failed cof or personal hygiene related aving for 1 (Resident #16) of ved. The facility also failed to trelated to high for Resident #65.		What corrective action(s) will be accomplished for those residents by the deficient practice? Resident #217 Activity of choice v reviewed with resident and a deck was provided. Resident #65 medication wer reviewed by MD, change was ma physician order. Resident receive per schedule. Resident #16 was assisted immer with his oral care and shaving. Resident #85 glass of water, OJ, chips were removed immediately. Resident was re-educated on her diet and the potential risk if not for those well in the potential risk if not for the well in the potential risk if not for the properties of the province and the potential risk if not for the province and the potential risk if not for the province and the province and the potential risk if not for the province and the	vas to for cards t
	During this interview	Resident #217 responded, "No. w Resident #217 explained acility because of an	Į.	action will be taken. Current residents were re-intervie	wed for

stated that she prefers independent activities. AHCA Form 3020-0001

that she is at the facility because of an

An

explained that it is difficult for her to get out of bed, and that she prefers to be in her room. She

... to her

also noted to her right

device was

. The resident

their preferences in activities, changes

were made accordingly.

Current residents receiving with order for parameters were audited to ensure compliance, none was identified

Agency for Health Care Ad	ministration			NTED: 10/12/2016 ORM APPROVED
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	95032	B. WING		09/22/2016
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CONSULATE HEALTH CARE	OF WEST PALM E 1626 DA	IVIS RD ALM BEACH,	FL 33406	
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N 201 Continued From p	page 16	N 201		
AM Resident #21 room. As per her at physician appop During a subsequ 12:50 PM Reside frustrated as she appointments, an out, again stating room. When aske anything to do in not. When asked volunteered, "I liv explained that she njoys Solitaire."	14 PM and 09/21/16 at 10:34 7 was noted to be out of her roommate, Resident #217 was intrents. Jent interview on 09/21/16 at nt #217 stated that she was has had numerous physician of when she returns she is worn that she prefers to be in her da again if staff have offered her her room, she stated they had if she had any books or cards that she did not have either, and e for cards." Resident #217 e plays cards with a group and she stated that she bought an earne, but can't get it to work.	3	by this alleged deficient practice. Current residents who require assista with oral care and shaving could have been affected: observation was conducted none was identified by this alleged deficient practice. Current residents with diet could have been affected by this alleged deficient practice. An audit was conducted to ensure residents with diet do not receive OJ, potato chips a no at bedside; none was identified this alleged deficient practice. What measures will be put into place what system changes will be made to ensure that the deficient practices do not recur:	d :
Resident #217 st of cards to play S Review of the rec admitted to the fa to include a admission MDS (in comprehensive a documented Res Interview for Men indicating she is Activity Preferency documented it is Activity Preferency	ord revealed Resident #217 wa	S	Activity Director and staff were in-sen on providing activity per resident choi and interest. Activity Director will revi new admission and current residents their initial and quarterly assessment ensure resident received activity of the choice. Licensed staff was in-serviced on me error, following MD order with residents and 'parameters. Unit Managers will review MAR twice weekly to ensure compliance. Findin will be reported to DCS. Nursing staff were in-serviced on offe and assisting residents with oral care	ce ew on to eir d

AHCA Form 3020-0001

shaving. Unit Manager/department head

care, shaving is provided and will report findings to morning meeting.

on residents with . | diet and

will check daily on residents to ensure oral

activities.

comprehensive assessment also documented

that it is very important for her to have her favorite

Review of the Activities Evaluation, completed on

by the Activities Director, documented

Agency for Health Care Ad	ministration			PRINTED: 10/12/2016 FORM APPROVED
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N 201 Continued From	page 17	N 201		:
assessment doo. are very importar animals/pets, car music, reading an assessment doo. "small group" act she enjoys both playing of cards. Review of the cu documented Res room and that he coffee hour, food book club, and T During an intervie Activity Director or activities initial as Resident #217. th she doesn't like t be in The that Resident #22 TV, and likes to r she offered Resis when she first go items to read ead with a cart. Wher documents if any Activity Director or Activity Director or Activity Director or Resident #217 in she never though a Solitaire game her machine didir	erative and motivated. This immented current interests that it to the resident as ds, family/firend visits, movies, d television. Although this immented the card interest as a vity, Resident #217 stated that imal group and independent rent activities care plan ident #217 prefers to stay in her interests included card games, snacks, in room visits, music, snacks, in room visits, music,	Company of the Compan	. CDM will monitor resident tray three times per week to ensu accuracy. Nursing manager/department hea monitor resident's room daily to eresident with has rediside and diet order is followed. How the corrective action(s) will be monitored to ensure the deficient will not recur, i.e. what quality assprogram will be put into place. DCS/designee will report findings monthly until substantial complian maintained.	re id will insure io

Activity Director stated that she does it quarterly. The Activity Director stated that she had not AHCA Form 3020-0001

and when she re-assesses her interventions, the

Agency for Health Care Adm	injetration			FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 201 Continued From pa	ge 18	N 201		
re-assessed Reside	ent #217.			
that the resident wa with diagn The resident was so treatm facility three days a 12:30 PM and retur Monday, Wednesda monthly physician o	nents in a community week leaving the facility at ning after 5:00 PM on ay and Friday. The following rders were not followed to received the prescribed			
resident to receive one tablet by mout days until after and Friday. Admini Medical (MAR) documented and noted the nurse appropriate boxes I administered daily differentiation on was held and given the resident went to the control of the nurse of than hold for than hold for than hold for	es placed their initials in the ndicating the medication was			

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The MAR documented 7 times at the 2:00 PM dose, the nurse circled their initials indicating that the medication was not administered (

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 201 Continued From page 1	19	N 201		
However the back of the the 7 circled doses on "not given because here she was conducted and the staff of the same she was conducted and the same she was c	ident. She stated she ications to the resident as the but she center asking for them to medication had been but on this. Used on 09/21/16 at 10:10 anager and the Assistant le surveyor reviewed with esident's on. Concerns were resident's and n. The prescribes for the in days and given is from The at the medication was M daily and not held on bed. The staff confirmed indicated that the nurses cian order for			

be administered on these days to ensure the resident did not miss doses of medication to treat

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days and the staff did not obtain clarification orders on how the medication was to

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Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
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N 201	Continued From pa	ge 20		N 201			
	her			-			
	that the resident was contained are These observations AM the resident was lying in bed. He was and 09/20/16 at 9:44 AI in his wheelchair, the remained unshaver AM, the resident was lying in bed, the resident was lying in bed, the resident was likely and	itions of Resident #11 its unshaven and his teeth were not is include: On 09/140 is observed to be dries unshaven and hat on his teeth; M the resident was one resident was observed to be dried to the dried of the dried to the dried of Resident was observed to be dried of the dried of th	mouth t brushed 16 at 11:37 essed and d noted on out of bed seed but at 11:45 ressed and haven and				
		nducted with the resi					:
	at 11:37 AM, the re brush his own teeth he had not been pr toothpaste and had teeth. He further sup but did not shaw with the resident again conf teeth this morning, not offer him oral h to brush his teeth. unshawen and he c shawed him or offer The clinical record	sident stated he was in citied the toothbrus or of ided the toothbrus in ot been set up to I bated the aide had we him. During the in 09/21/16 at 11:45 A irmed he had not bright he had not bri	s able to onfirmed sh or				
	on the Mi (MDS) the resident	nimum Data Set Ass ∷is	essment of				

AHCA Form 3020-0001 STATE FORM

If continuation sheet 21 of 23 ILLV11

for dressing and personal hygiene.
The aide KARDEX also indicated the resident is
for activities of daily living.

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Agency for Health Care Adm STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	INISTRATION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
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N 201 Continued From pa	nge 21	N 201					
beginning at 12:22 Nursing Assistant (the resident a bed confirmed she did the resident with or she did not ask the mouth care. The re teeth. She was ass three days, Monda gave the resident shave the resident She then stated the refuse but she adnresident. 4. During an obser conducted on 9/20 of ice water was at speaks very little E	onducted on 09/21/16 PM with Staff D, the Certified CNA). She stated she gave bath this morning but not shave the resident or assis: al care. She also confirmed resident about shawing and sident can brush his own igned the resident for the past y through Wednesday. She a bed bath but she did not or set him up for mouth care. at the resident will sometimes nitted she did not ask the vation of the resident room /16 at 2:52 PM, a 12 oz glass the bedside. The resident whe rightsh, could offer no whether she requested it. On	1000					
the bedside table t which is very high	here was a bag of potato chips food.	•					
physician order for diet, and							
acknowledged that been served the 1	8:12 PM, the unit manager B t the resident should not have 2 ounces of water. She further t buys the potato chips on her	and the state of t					
	AM an observation of the caled 4 oz of Orange juice was						

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juice (a very high

served instead of the Apple Juice marked on the menu slip. When the surveyor questioned whether the resident is allowed to have orange

beverage), the nurse

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Agency for Health Care Adm STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
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CONSULATE HEALTH CARE OF WEST PALM E 1626 DAVIS RD WEST PALM BEACH, FL 33406								
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N 201 Continued From pa	age 22	N 201						
removed the orang protest.	e juice. The resident did not							
allowed on a for nutrition and hy areas of potential relationship and the state of	at orange juice is not usually idiet. Review of the care plan oration reveals identified focus utrition and fluid imbalances. he clinical record reveals rom the center or (5.8mg/dl) in in the month of (5.8mg/dl) in in the month of oration or the center o	n n						
		Ì						

AHCA Form 3020-0001

STATE FORM





ELIZABETH DUDEK SECRETARY

September 30, 2016

Administrator Consulate Health Care Of West Palm Beach 1626 Davis Rd West Palm Beach, FL 33406

RE: Recertification surveys

Dear Administrator:

On September 19, 2016-September 22, 2016, Recertification, Licensure and Life Safety Code surveys were conducted in your facility by representatives of this office.

The purpose of this visit was to determine if your facility was in compliance with requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found not in substantial compliance with the participation requirements.

Enclosed are the provider's copies of Form CMS-2567 (Statement of Deficiencies and Plan of Correction) and State (3020) Form. These forms reference the deficiencies that were identified during the visit.

You will not receive a copy of this letter and attachments in the mail; you will only receive this electronic report.

A Plan of Correction (POC) for the deficiencies must be submitted to this Field Office 10 days after your facility receives the faxed Form CMS-2567. Failure to submit an acceptable POC within ten (10) days after receipt of the faxed statement of deficiencies may result in the imposition of remedies. You will be notified by telephone or fax if your POC is found to be acceptable. If your POC is found to be unacceptable, you will be informed in writing. The correction date indicated by the facility shall be after the date of survey exit. **Deficiencies** shall be corrected no later than October 22, 2016.

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systematic changes you will make to
 ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not

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 Consulate Health Care Of West Palm Beach September 30, 2016 Page 2

recur, i.e., what quality assurance program will be put into place.

Recommended Remedies:

Please note that this letter does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other sanction is warranted, we will provide you with a separate formal notification of that determination.

Remedies will be recommended for imposition by CMS if your facility has failed to achieve substantial compliance by the revisit. Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended. A change in the seriousness of the noncompliance found may result in a change in the remedy recommended. When this occurs, you will be advised of any change in remedy.

- · Civil Money Penalty, in an amount and duration to be determined by CMS.
- A mandatory denial of payment for new admissions will be imposed December 22, 2016 if substantial compliance is not achieved by that time.
- Termination of Medicare Agreement. We are recommending to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on March 22, 2017 if substantial compliance is not achieved by that time.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, the CMS Regional Office or State Medicaid Agency will impose the other remedies indicated above, or a revised remedy, if appropriate.

Informal Dispute Resolution:

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

> Attention: IDR Coordinator Agency for Health Care Administration 2727 Mahan Drive, Mail Stop 9-A Tallahassee, Florida 32308 FAX (850) 414-6946 or

Phone number: (850) 412-4301 IDRCoordinator@ahca.myflorida.com

The IDR request must be sent during the same 10 days you have for submitting a Plan of Correction for the cited deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Consulate Health Care Of West Palm Beach September 30, 2016 Page 3

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 surveyor(s). If you have questions, please contact the Delray Beach Field Office at (561) 381-5840.

Sincerely,

Maryanne Salerni for

Arlene Mayo-Davis Field Office Manager

AMD/ms Enclosure

R6WB