STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968825	R 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRISTAL PALACE RESORT PB LLC	**1881 PALM BAY RD NE** **PALM BAY, FL 32905**

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0000 - Initial Comments

A revisit to complaint investigation #2017004739 was conducted on , , , and . In addition, complaint investigations #2017006089, #2017005680 and #2017006998 and revisits to complaint investigations #2015008062, #2016007263, #2016004743, #20160016024, #2017004557, #2016009950, #2017004040, #2015011302, and a revisit to an ECC monitoring visit were conducted on the same dates.

Cristal Palace, license #12660, had deficiencies related to the revisit to #2017004749 at the time of the visit.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

DEFICIENCY REMAINED UNCORRECTED

Based on resident record review and interview the facility failed to provide a completed AHCA Form 1823 Health Assessment and the facility failed to provide a current & correct 1823 Health Assessment upon admission into the facility from the healthcare provider for 8 of 21 sampled residents (#4, #7, #11, #19, #21, #22, #24 & #32).

Findings:

1. Resident #22's record review revealed a current AHCA Form 1823 Health Assessment not completed by the healthcare provider after a significant change. In further review, the date of the admission was on .

On at 1 PM, an interview with staff G & staff I who confirmed the findings.

2. Resident #24's record review revealed date of admission into the facility on and had a AHCA Form 1823 Health Assessment dated from another facility upon admission into this facility on .

On at 1:30 PM, an interview with staff G & staff I who confirmed the findings and further commented they were not able to locate the current new admission 1823 Health Assessment for resident #24.

3. Resident record review for resident #11 admitted , revealed a health assessment form 1823 was not available.

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4. Resident record review for resident #19 admitted on revealed a health assessment report 1823 dated that did not address the residents needs regarding . That portion of the assessment report was blank.

5. Resident record review for resident #21 admitted revealed a health assessment form 1823 was incomplete. The only page available was page 5 of 5.

In an interview with the facility's Licensed Practical Nurse (LPN) on at 11 AM who confirmed the findings. She explained she was unable to locate the health assessments for residents # 11, #19, and #21.

6. Record review for resident #4 revealed a health assessment form 1823 that was dated on .

The question on the form that pertained to whether she required 24-hour nursing or care was not answered.

Her record contained no documentation to indicate the facility obtained the omitted information from a health care provider.

On at 3:45 pm, staff J confirmed the finding.

7. Review of the record for resident #32 revealed an 1823 dated , which documented a diagnosis of and . She had left sided and required assistance with all ADLs, except independent with eating and supervision with transferring. No documentation of the type of assistance required for medications was noted. That part of the form was left blank.

In an interview with the administrator on at 4:15 PM, she said she did not know the 1823 was incomplete.

8. Record review for Resident #7 there was no resident Health Assessment form 1823 found in her record.

Staff G reviewed the record and returned with a Resident Health Assessment form that did not include

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the health care providers name, signature, title address, telephone number and date the form was completed.

On at 11:00AM Staff G confirmed the health care provider had not completed the form as required.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observations, record reviews, and interviews the facility failed to ensure a licensed nurse was available to administer medications for 2 of 2 sampled residents (#6 and #23).

Findings:

1. Staff J was identified as a contract nurse who was at the facility every morning and every evening to assist residents with glucose testing, administration and to administer any medications that required a licensed nurse to administer.

Observations made on at 3:30 pm revealed the daughter of resident #6 requested that her mom be given her because her reading was 172. Staff G, an unlicensed caregiver, told her the facility was unable to access the medication for resident #6 because staff J took the key to the nurse's medication cart home with her. Staff G also said that the unlicensed staff were unable to administer the medication to resident #6 and that a nurse was not available in the facility.

The daughter of resident #6 said that if the facility had the key to access the medication, she would have been able to give the medication to her mom. She said she was a registered nurse and that she checked her mom's .

The administrator and staff G told the daughter that resident #6 would be sent to the hospital. Her daughter declined and said she did not want her mom to be sent to the hospital.

Review of the 2017 Medication Observation Record (MOR) for resident #6 revealed an entry for 6.25 milligrams (mg) 1 tablet by mouth once daily (hold for less than 100 or rate less than 60) to be done by a facility nurse.

On at 4:00 pm staff J, a licensed nurse, arrived to the facility and confirmed that she had taken

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the key to the nurse's cart home with her. Observations revealed that staff J approached resident #6 and checked her , using an electronic wrist device. The reading revealed her , was and her rate was 96. Staff J administered the to resident #6.

Record review for resident #6 revealed that she had diagnoses of , , , , , and a with .

2. Observations made on at 11:15 am revealed that resident #23 was sitting in the facility lobby. She said that earlier, while she sat outside, she became a little shaky and she believed her sugar was low. She said there was no staff at the facility who could check her sugar for her, that she was told only a nurse could do that. She said she drank some orange juice and ate some candy.

During an interview with staff G on at 11:20 am, she said there was not a nurse at the facility to check the sugar of resident #23 and that she would have to be sent to the hospital. Resident #23 declined to be sent to the hospital. Staff G said she would give resident #23 her supplies to see if she was able to check her own sugar.

Observations made on at 11:27 am revealed that with verbal prompting from staff G, resident #23 put a needle on the lancet device, placed a test strip into the glucose machine, and stuck her finger with the lancet. While staff G guided her finger to the test strip, resident #23 placed a drop of on the strip. The glucose machine indicated that her sugar was 83.

During an interview with the Advanced Registered Nurse Practitioner (ARNP) for resident #23 on at 4:15 pm, she said that she previously told the facility that resident #23 was a labile and that her sugars needed to be checked four times a day. The facility administration previously asked her to change the sugar checks for resident #23 to twice a day because the facility did not have a nurse. She said she was aware of the events from that morning regarding resident #23 and her sugar and that she gave an order for resident #23 to have her sugar checked four times a day. She said the facility staff told her that the resident would check her own sugar at bedtime.

During an interview with the administrator on at 4:35 pm, she confirmed the facility received an order from the ARNP, dated , to check the sugar of resident #23 four times a day. She said resident #23 would check her own sugar at bedtime. The observations made on at 11:27 am that revealed resident #23 was unable to check her sugar without verbal and physical assistance, was discussed with the administrator. The administrator said she would have a licensed nurse at the facility to assist resident #23 with her sugar and at bedtime.

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Record review for resident #23 revealed that she had diagnoses of type 2. She required assistance with her medications. A review of her most recent health assessment form 1823 that was dated on revealed a health care provider order for to be given based on sliding scale coverage before meals and at bedtime for .

A health care provider order that was dated indicated that she was to have a finger stick twice a day before meals.

Review of the personnel record for staff J revealed a job offer that was dated . It indicated that the job duties for staff J included administering medications that required to be administered by licensed personnel.

Class III

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

Based on record reviews and interview the facility did not keep an up to date Medication Observation Record (MOR) for 13 of 21 sampled residents (#3, #6, #8, #9, #12, #13, #14, #16, #25, #24, #26, #27, and #28)

Findings:

Review of the Electronic Medication Observations Records (MOR) revealed there were blank spaces and there was no explanation as to whether or not the residents received their medications as follows:

1. Resident # 9
, 5 mg @ 7:30 AM and was marked as given on , . On , the MOR indicated held according to Doctor (DR) orders.

2. Resident # 13
100 mg at bedtime had staff initials circled and indicated held According to DR/RN orders.
, 25 mg twice a day was blank on AM and PM.

3. Resident #14
, - one every 6 hrs. As needed "control" was marked as given on "x3" - - 8:51 PM "good effect", 8:57 PM good effect and 10:40 PM good effect. The count sheet indicate 49 pills available and 49 on bubble pack.

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Only 1 pill was used on .

4. Resident # 16
Donezapil 5 mg daily, 20 mg daily, 5 mg daily were blank on
Mamantine one twice daily at 8AM and 5PM was blank on in AM

In an interview with the facility's Licensed Practical Nurse (LPN) on at 11 AM who confirmed the findings and the MOR was a new computer system. Since the staff were learning sometimes, they selected the wrong code for missed medications since the real reason may not be one of the choices in the system. The MOR was not accurate. As for the blanks, the resident likely got the medications. However, they were not marked as given.

Review of the Electronic Medication Observations Records (MOR) revealed there were blank spaces and there was no explanation as to whether or not the residents received their medications as follows:

5. Resident #3
CL ER 20 MEQ one twice a day was left blank at 5 PM on 7/7,
100 Milligrams (mg) 1 daily was left blank at 8 AM on
ER 30 MG 1 every 8 hours was left blank at 2 PM on
Doc-Q-Lace 100 mg 2 twice a day was left blank at 5 PM on 7/7 and
SR 150 1 daily was left blank at 6 AM on 7/9

6. Resident #8
100 mg 1 three times a day was left blank at 8 AM on 7/8
10 mg one daily was left blank at 8 AM on 7/8
Asper crème apply to lower back three times a day once each shift was left blank at 8 AM on 7/8
325 mg one daily was left blank at 8 AM on 7/8
10 mg 1 at bedtime was left blank at 9 PM on 7/7
SOD DR 500 mg 2 at bedtime was left blank at 9 PM on 7/7/

7. Resident #12
1% Gel apply 2 grams to affected area (s) four times daily was left blank at 4 PM from 7/4 through
25 mg 1 and 1/2 tablets (37.5 mg) once daily in the morning on empty stomach was left blank at 7:30 AM from 7/4 through .

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On at 2 PM staff G reviewed the MORs and said the residents did receive their medications. She said it was a new electronic MOR system and the staff had not been trained on how to make entries. On at 4:25 PM, a pharmacy technician from the new pharmacy the facility was using said the previous nurse who no longer worked at the facility was trained on the new electronic MOR system and she was supposed to train the other staff. He said he was there to train the nurse that was now working at the facility so that she could train the staff. He said none of the staff who provided assistance with the self-assistance with medication was trained on how to use the new system.

8. Review of the , 2017 electronic MOR for resident #6 revealed an entry for , 10 milligrams (mg) 1 tablet by mouth three times a day for , and it was scheduled to be given at 8 am, 1 pm, and 5 pm. The 1 pm dose on was blank and not signed as given.

20 mg 1 tablet by mouth once daily for was scheduled at 8 am. The dose on was blank and not signed as given.

325 mg 1 tablet by mouth twice a day was scheduled at 8 am and 5 pm.

On , every scheduled dose for the , , , and contained circled initials. The explanation on the MOR indicated that the doses were withheld per a doctor or registered nurse orders.

During an interview with staff J on at 3:36 pm, she said she believed resident #6 received her , on and the unlicensed staff just forgot to sign the MOR. She said she did not know why the dose was blank on and resident #6 did not usually refuse the . She said she believed the unlicensed staff chose the wrong option in the computer when the MOR indicated that the , , , and were withheld on . She said there was not an order from a health care provider to withhold the medications. She said the computer software was new and she believed the staff just did not know how to use it.

9. Review of resident #24's , 2017 Medication Observation Record (MORs) revealed holes of missing dates , , and for all medications listed.

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On at 2 PM, an interview with staff G whom offered no comment and confirmed the findings.

10. Review of resident #25's , 2017 Medication Observation Record (MORs) revealed holes of missing dates & for all medications with additional missing dates on , & for D3 1000 units softgel at 1 capsule by mouth once daily.

On at 2:05 PM, an interview with staff G who offered no comment and confirmed the findings.

11. Review of resident #26's , 2017 Medication Observation Record (MORs) revealed holes of missing dates , , , , , , and for 25 mg at 1 tablet by mouth every day.

On at 2:10 PM, an interview with staff G who offered no comment and confirmed the findings.

12. Reviewed resident #27's , 2017 Medication Observation Record (MORs) revealed holes of missing dates & for all medications with additional missing dates on , & for / 10-325 mg at 1 tablet by mouth twice a day at 6am and 6pm. Missing dates on for 3.125 mg at 1 tablet by mouth two times a day. Missing dates on , & for 290 mcg at 1 capsule by mouth every day 30 minutes prior to breakfast.

On at 2:15 PM, an interview with staff G who offered no comment and confirmed the findings.

13. Reviewed resident #28's , 2017 Medication Observation Record (MORs) revealed holes of missing dates for , 325 mg at 1 tablet by mouth once daily.

On at 2:20 PM, an interview with staff G whom offered no comment and confirmed the findings.

Class III

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

Based on observation of medications, record review and interview the facility disposed of medications of unknown residents without consent of the residents or their representative. 1) Did not document the disposal in the residents records, did not return medication to 6 of 6 sampled discharged residents (#33, #36, #37, #38, #39 & #40) or their representatives, and after notification and waiting at least 15 days for

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the resident and or the family to pick up the medication or dispose of it. 2) And failed to ensure that centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication" for 1 of 21 sampled residents.

Findings:

On at 9 AM, Staff G said the previous nurse instructed the staff to remove all of the residents of the facility's additional medications that were not in use from the cart that was from the old pharmacy because the new pharmacy would be providing medications. She said the staff removed the medications as instructed. She said the old pharmacy came out to pick up the medications and was later instructed to bring it back, the old pharmacy did return the medications in totes. She said after the medications were returned the new pharmacy then came to take the medications with them to dispose of them.

Staff G was asked to provide a list of the medications and the names of the residents who the medications belonged to. She said the facility did not document anywhere, the name of the medications and the name of the residents whom the medications belong to. She said it was several totes with large amounts of medications. She said the residents were current residents and it was their medications they were currently taking or some that may have been discontinued. She said she was informed the new pharmacy would be giving the medications to a homeless organization.

On at 12 PM, a telephone interview was conducted with the pharmacy tech /Business Development for the new Pharmacy. He said the pharmacy are usually on a 3 week cycle for delivery. When his pharmacy took over the old company came to take their medications back to the pharmacy. He informed the facility to call the pharmacy to have them bring the medications back because the medication was already paid for, they may not be able to get another prescription until the next month, and the residents would be without medication. The old pharmacy brought the medications back in totes. He received a call from the previous facility nurse saying they would be having a mock survey and the medications needed to be out of the building. On , the van from the new pharmacy was supposed to come to get the medications from the facility and they had arranged for that. He said a pharmacy employee asked him if he would bring the medications because he was already at the facility on . He said he agreed and did take the medications. He said the new pharmacy that he was employed by would donate unused medication to the Medical Clinic for the homeless and he gave the name. The medical clinic had a license to receive unused medication. He said before giving the medication to the clinic. All of the names of the residents had to be removed due to HIPPA. He said the names were blackened out on the prescription label. He said he was informed that all of the medications that were taken and labels removed were going to be taken back to the facility.

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The facility did not ask the residents (who were unknown) if they wanted to keep their medications that were already paid for prior to giving it to the new pharmacy to donate.

Observations on at 12:15 PM revealed a drawer located in the clinical station that had medications inside. The facility's License Practical Nurse (Staff J) said at the time the medications were and medications of some residents who were discharged and some were current residents. She said the facility had not notified the resident or their family to come to obtain the medications. Further review of the medications revealed the following for the discharged residents:
For resident #36 discharged on there was a package of Sodi Tablets 88 mcg, a package of 50 mg, a package of - 5-325, 2 and 1/2 package of 0.25 mg
Resident #37 discharged there was a package of Mono Ter 30 mg and Tartrat 25 mg
Resident #38 discharged on there was a package of / 5-325 mg and 5 mg
Resident #39 was not a resident, his discharge date was not listed on the admission and discharge log had a package of Patches 50 MCG
Resident #40 was mot a resident and her name was not listed on the admission and discharge log had a hospice comfort pack

Resident record review for resident #16 revealed an 1823 dated indicated diagnoses of and high . He needed assistance with self-administration of medications. An order dated indicated to discontinue . The medication review revealed a bubble pack with a prescription label dated that indicated 500 mg chew and swallow daily as needed that was stored with the residents' current medications and was not labeled as a discontinued medication.

In an interview with staff L on at 11AM who stated she did not know why the discontinued medication for resident #19 was in the cart.

Class III

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

Based on observations, and interview the facility did not make sure when the directions for use of medications were "as needed", the health care provider was contacted and requested to provide revised instructions. That indicated the circumstances under which it would be appropriate for the resident to

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request the medication and any limitations must be specified for 1 of 21 sampled residents (#19).

Findings:

Resident record review for resident #19 admitted on revealed a health assessment form 1823 dated that indicated diagnoses of and . Assistance was needed with self-administration of medications. Medication review on at 11:00 AM revealed prescription labels dated that indicated lax 50.8 daily as needed, 650 mg daily as needed and 500 mg chew and swallow daily as needed. Continued review revealed no evidence that a healthcare provide order was obtained to clarify under what conditions should the resident request the medications.

In an interview with staff L on at 11:00 AM who said, she did not have access to the order in the computer only the Registered Nurse and the pharmacy did, so she was unable to check for a revised order.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

DEFICIENCY REMAINED UNCORRECTED

Based on observations, menu review and interview the facility did not maintain menus dated for the week in use and did not conspicuously post the planned menus for the residents to review. In addition, the menu was not followed as planned and approved by the dietitian.

Findings:

Observations on at 11 AM, noted the menu was posted in the back of the large dining area on a board on the wall. The menu posted was not dated.

On at 12:15 PM while residents waited for their food, several residents were asked if there were aware of where the menu was posted. The resident interviewed did not know where the weekly menu was posted. They only knew what they were eating when they came to the dining area. Observation noted some residents used wheelchairs and motorized scooter and did not go into the back of the dining area where the menu was posted to eat their meals.

Observation of the menu for Monday revealed it noted baked chicken, rice, peas, tossed salad

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and dinner roll or a ham sandwich as substitution.

The lunch served was roast pork with gravy, French fries, mixed vegetables and banana pudding. Observations during lunch noted some residents ate the roast pork meal; others had grilled cheese sandwich and French fries. One resident had a special order- grilled Swiss cheese sandwich. One resident requested a fruit platter and another resident requested a special order- egg salad and fruit.

The dietary manager stated on at 12PM that she tried hard to please the residents and make special orders but that sets her back a bit. She was told that the menu posted was a guideline for her to follow, not to necessary follow that menu, as she did not have any other menus. She severed a protein, vegetables, carbs and dessert. She made exchanges of equal nutritional value.

In an interview with the owner on at 11 AM who stated the facility had menus.

Class III

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

DEFICIENCY REMAINED UNCORRECTED

Based on observation and interview the facility failed to provide and maintain a safe living environment; and the facility failed to ensure that all existing architectural and structural systems were in good working condition pursuant to Section 429.28(1) (a) Florida Statute.

Findings:

1. During the tour observation on at 10 AM there were some white like slime bubbles or particles floating & forming inside the facility at the indoor swimming pool. Further observation revealed the outdoor swimming pool was filled with sand. This was done without authorization from the Brevard County Department of Health (DOH) confirmed by an unsatisfactory inspection report dated .

2. On at 10:30 AM, an observation of dirty black stains on the carpet located in front of the 1st & 2nd floor elevators, in the hallways of both 1st & 2nd floors Also, heavily stained carpet was observed in front of doors for : #114, #118, #122, #124, #125, #128, #129, #205, #208, #212, #223, #230, #232 and white like stains on the carpet in front of : #104 & #112. There was a metal part protruding out of the lower wall in front of : #112 & #114 across from the Electrical the 1st floor.

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3. On at 10:45 AM, an observation on the second floor red box fire extinguisher case has black like substance inside, immediately at the corner before # . This was observed previously on .

On at 2 PM, an interview with the Administrator informing her of the physical plant concerns, and she stated to inform the Maintenance Director.

On at 11:45 AM an interview and walk through to look at all the physical plant issues with the Maintenance Director who offered no further comment and confirmed the findings.

4. On at 10 AM, during tour observation of a yellow barrier tape "Warning, Do Not Enter" and a written sign on the women's & men's downstairs front lobby public stating out of order. In addition, near that area of the lobby where residents and guest walked there was a bad sewage like odor backing up.
On at 11:30 AM, an interview with staff G about the bad smell in the front lobby, near the public and she stated the Maintenance Director was contacting a plumber because the have been out of order for a day.

On at 12:45 PM, an interview with the Administrator who confirmed the front lobby were out of order & and she and the Maintenance Director would speak to the owner.

On at 2 PM, an interview with the Administrator who stated that the Owner was calling the plumber to look into the problem with the front lobby .

On at 9:30 AM, the front lobby was still out order and smelled bad like sewage back up.

On at 12 PM (noon), the Brevard County Department of Health Inspector came to the facility and stated that she was going to complete a full health inspection because she received a referral about the front lobby public and out of order. The inspector further stated that she would conduct the full food hygiene inspection today and inspect the full group care inspection on tomorrow.

On at 4 PM, an interview with the Administrator who confirmed that a plumber was called and it was described to her that it was the flushing system would have to be repaired. The flushing power is not strong because the toilet systems are outdated.
The odor could be smelled in the common area on the first floor.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968825	R 07/13/2017
NAME OF PROVIDER OR SUPPLIER **CRISTAL PALACE RESORT PB LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1881 PALM BAY RD NE** **PALM BAY, FL 32905**	

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

On at 4 PM at exit conference, the front lobby were still out of order.

5. Observations of the 3rd floor on at 5:20 PM revealed the was inside of the was converted into the dining , did not have a toilet. There was a large hole in the wall, the sink's counter top was cracked, and there were two a mop and a dustpan inside of the shower.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Revisit conducted. Deficiency A160 remained uncorrected.

Based on record review and interview the facility did not maintain an up - to -date admission and discharge log.

Findings:

Review of the admission and discharge log revealed there were residents who were discharged and the log did not indicate the reason for discharge and place discharged to.

On at 11 AM, staff G confirmed the findings.

Class III