STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943102	10/25/2018
NAME OF PROVIDER OR SUPPLIER **SAVANNAH COURT OF THE PALM BEA**	STREET ADDRESS, CITY, STATE, ZIP CODE **2090 N. CONGRESS AVENUE WEST PALM BEACH, FL 33401**	

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

0000 - Initial Comments

An unannounced licensure complaint investigation, CCR #2018014564, was conducted on and , concluding on at Savannah Court Of The Palm Beaches, License #8367. The facility had deficiencies identified at the time of the investigation.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and an interview, the facility failed to ensure a resident who encountered a significant change in condition had a face-to-face medical examination documented by a health care provider (AHCA Form 1823); and, failed to continuously monitor for appropriateness for continued residency in an Assisted Living Facility (ALF), for 1 out of 3 sampled residents (Resident #2).

The findings included:

On , Resident #2 was noted in the Nurse's Notes to have a "small opening to the left (bottom)". This pressure was a significant change in the resident's condition as defined in 58A-5.0131, F.A.C., requiring a new health assessment (AHCA Form 1823) to be completed. The last health assessment on file for this resident was dated .

On , the hospice RN (Registered Nurse) documented that the resident had " (pressure sores) to the sacrum (bottom) and (both) hips". There was no documentation since the date of onset of the pressure on the resident's bottom ( ) to show that it had improved. The resident had 3 pressure sores as of .

During an interview with the current Administrator on at 2:00 PM, she acknowledged the documentation and was unable to comment on the resident's status in 2017 as she was not employed by the facility at that time. She acknowledged that the resident's notes indicated that the resident was declining in overall health and that hospice was caring for the wounds as their documentation showed.

Based on the above findings, the facility failed to obtain a new health assessment upon a signficant change for Resident #2. The previous administration failed to monitor for continued residency for Resident #2 who should have been discharged from the ALF when the pressure did not improve within 30 days as required.

These findings were discussed with the Administrator and Staff C on at 3:00 PM. The facility provided no additional documentation for review at the time of the survey.

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Class III

0031 - Resident Care - Third Party Services - 58A-5.0182(7) FAC

Based on record review and interviews, the facility failed to ensure a third party provider coordinated services with the facility regarding a resident's condition and the service provided, for 1 out of 3 sampled residents (Resident #1).

The findings included:

On at 10:30 AM, it was revealed that Resident #1 had received a new order dated for medicated powder from a mobile company that visited the facility. Review of the consult note dated showed that the resident was "being monitored for skin on an annual basis" and that the resident has a "complaint of skin , located on the trunk. The are rough and raised, darkening, scaly, enlarging, irritated, and itchy and moderate in severity". The plan noted on the consult report documents, "Follow up in 3 months". A previous consult note dated showed no plan for follow up or continued planned visits by this company.

During interview with Staff C on at 1:00 PM, she acknowledged the dermatologist company's treatment of the resident on . She stated that the facility keeps a list of residents who request to be assessed by the dermatologist on a monthly basis, and showed the last list of residents who were to receive a visit from the company on . Resident #1's name was not listed. After contacting the company to find out why the resident was seen, she stated that an unknown staff member reportedly requested the provider to see the resident on . There were no Nurses Notes documented to show a complaint of " " or other medical condition to warrant the third party provider's assessment and treatment. This unsolicited request for treatment did not follow the facility's protocol for third party provider visits.

Review of the facility's Third Party Provider policy documents that the facility will "ensure coordination and communication of services provided between resident, third party provider and community".

These findings were discussed with the Administrator and Staff C on at 3:00 PM. They acknowledged that the resident's representative should have been notified of the requested consult and treatment prior to the resident being seen. The facility provided no additional information for review at the time of the survey.

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Class III

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

Based on record review and interviews, the facility failed to accurately complete the Medication Observation Record (MOR) at the time the medications were to be given, for 2 out of 3 sampled residents (Residents #1 and #3).

The findings included:

1. On at 11:00 AM, the 2018 MOR for Resident #1 was reviewed. The MOR showed that the resident was to receive ( ) for 5 days starting . The MOR was blank with no initials by staff to indicate the medication was provided on at 9:00 AM and on at 9:00 PM. There was no remaining supply of the 5 day to determine if the documentation errors were indicative of missed doses or omitted staff initials.

2. On at 11:00 AM, the 2018 MOR for Resident #1 was reviewed. The MOR showed that the resident was to receive , twice a day at 9:00 AM and 5:00 PM. The MOR was blank with no initials by staff to indicate the medication was provided on and at 5:00 PM.

3. On at 10:00 AM, Resident #3's 2018 MOR showed the resident's 9:00 AM dose of was not initialed as given. All other 9:00 AM medications had been initialed as given. On at 10:00 AM, the MOR was again reviewed and the 9:00 AM dose for this medication remained blank. Staff A had not initialed this dose as given. During interview with Staff C at this time, she acknowledged the missed documentation and showed that the current system for identifying whether the medication was provided as ordered showed that the resident had been given the 4 doses from the date the bubble pack was started, one daily as ordered. Staff C determined that this error was a documentation error.

These findings were discussed with Staff C and the Administrator at 3:00 PM on . The facility provided no additional information at the time of the survey.

Class III

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

Based on record review and interviews, the facility failed to make every reasonable effort to ensure

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medication was refilled timely, for 2 out of 3 sampled residents (Residents #3 and #4).

The findings included:

1. On at 10:30 AM, the supply of medications provided to Resident #3 by the facility was reconciled with the resident's 2018 MOR. The MOR listed 50mg PRN (as needed) as a current prescribed medication. This prescription was not available at this time, and the following circumstances were discovered:

a. 50mg PRN for pain: A scheduled prescription for 50mg was available and provided daily. During interview with Staff A at 10:30 AM on , she stated, "We can use the ones we have (from the scheduled prescription) if she needs it". She stated that the resident "doesn't want to pay for it". During interview with Staff C at this time, she stated that the PRN dose should be discontinued if the facility was not going to obtain the supply.

2. On at 10:45 AM, the supply of medications provided to Resident #4 by the facility was reconciled with the resident's 2018 MOR. The MOR listed and as a current prescribed medications. These prescriptions were not available at this time, and the following circumstances were discovered:

a. 150mg: On , the staff began initialing daily that the medication was "not on medication cart; nurse notified". On , a fax transmittal showed that the medication refill was requested from the pharmacy. On (Monday), this medication had not been received by the pharmacy. During interview with Staff C at 10:30 AM on , she stated that the pharmacy does not deliver medication on the weekends unless the nurse calls to specifically request delivery. She explained that the staff are expected to request refills for medications when there are 7 pills remaining in the supply. The request for a refill when this medication had 7 pills remaining in the supply had not been completed as required.

b. , 20mg: On , the staff began initialing that the medication was "not on medication cart; nurse notified". During interview with Staff C on at 10:30 AM, she stated that the staff are expected to request refills for medications when there are 7 pills remaining in the supply. The request for a refill when this medication had 7 pills remaining in the supply had not been completed as required.

These findings were discussed with the Administrator and Staff C on at 3:00 PM. The facility provided no additional information for review at the time of the survey.

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Class III