Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964897	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT DEER CREEK	2403 WEST HILLSBORO BLVD DEERFIELD BEACH, FL 33442

(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) COMPLETE DATE
A 000	Initial Comments An Assisted Living Facility complaint inspection (CCR# 2012012070) survey was conducted on . Emeritus at Deer Creek, had a licensure deficiency found at time of the visit.	A 000		
A 025 SS=D	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual. (c) General awareness of the resident ' s whereabouts. The resident may travel independently in the community. (d) Contacting the resident ' s health care provider and other appropriate party such as the resident ' s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.	A 025		

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A 025	Continued From page 1	A 025		

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure supervision, as appropriate for each resident, including the following: Daily observation by designated staff of the activities of the resident while on the premises and general awareness of the resident's whereabouts and safety. Resulting in a resident to resident altercation. (Resident #1 & #2)

The findings Include:

Resident #1 was admitted to the facility on [redacted] with a diagnosis to include [redacted] with [redacted] and [redacted]. A review of the facility service plan for the resident revealed the following: cognition info: memory, totally [redacted] cannot locate/recognize own [redacted]. Mental/behavior status requires daily safety checks (not related to [redacted]. Further review of the record revealed a note dated [redacted] found resident face down on the floor cut on her forehead. 911 was called, family and physician notified. Note dated [redacted] documented DCF was notified possible altercation resident to resident.

The incident report revealed the following: At 9:45 PM last rounds before shift change the resident was found on the floor by her bed with another resident standing next to her. Resident #1 was lying face down and [redacted] noted around the head area. Resident #2 was escorted out of [redacted] became very agitated. The interventions/preventive measures included: possibly put bed against wall, possible [redacted] for more security in bed situation. A written staff statement from the Medication Tech documented the top sheets to the bed were lying on the floor

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A 025	Continued From page 2	A 025		

as well and [redacted] surrounding her head. It took several minutes to get Resident #2 out of the [redacted]. A second staff statement documented Resident #2 was refusing to get out of Resident #1 ' s apartment and did not realize it was not hers. A third staff statement documented Resident #2 was standing over resident #1 and would not get out of the apartment stating "this is my [redacted] ' several minutes later Resident #2 was escorted out of the [redacted].

A review of Resident #2 ' s record documented an admission date as [redacted] the AHCA form 1823 was not dated and noted a diagnosis to include [redacted] and [redacted]. The additional comments included the patient needs an evaluation by psych. The resident ' s service plan dated [redacted] documented the following: psych mood: [redacted] with behaviors, history of exit seeking, constant reminders to find areas within the community, elopement risk and on [redacted]. A physician note dated [redacted] documents: discussed behaviors with staff. Wanders up all night, and the residents [redacted] medication was increased. Physician note dated [redacted] documents: [redacted] " wanders into peer [redacted] night and disrupts sleeping environment"

An interview on [redacted] at 10:13 AM with the Resident Care Coordinator and Executive Director, the Care Coordinator stated the facility does not have an elopement/ at risk book to identify wanderers. She also stated Resident #2 ' s actual move in date was [redacted] not [redacted] as indicated on the AHCA form 1823. The face sheet and Individual service plan dated [redacted] was from another facility. There was no evidence in the record of a data sheet or evaluation done at this facility. The Care Coordinator stated, she had

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A 025	Continued From page 3	A 025		

something in the computer and provided an individual service plan dated the plan did not identify any of the resident ' s behaviors. The plan included side effect monitoring and noted under mental/behavioral status may cause occasional interference with everyday functioning. There was no evidence of documentation related to behavior monitoring as indicated in the plan.

During a tour of the facility on at approximately 10:45AM with the Resident Care Director, Resident #1' s apartment was observed to have only a bed inside and it was not pushed up against the wall. Several staff members including the memory Care Unit Coordinator, stated they were not aware of any residents with behaviors that would include exit seeking or wandering.

Further review of Resident #1 ' s record did not reveal evidence of documentation related to daily safety checks (not related to as indicated on the resident ' s service plan. Resident #2 ' s record did not reveal evidence of documentation related to monitoring of the drugs as indicated on the residents service plan

A review of the facility policy Unsupervised Absence management. Documents the following: " Resident care director or designee evaluated the resident using the comprehensive evaluation tool ... Residents who have a history of wandering, and/or diagnosis of , Organic or related may need further follow up and evaluation with their healthcare provider. "

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A 025	Continued From page 4 A request to the Executive Director for in services regarding wandering/elopement and behaviors was requested. A sign in sheet identified only 37 employees participated on in the elopement training. There was no evidence of documentation the facility assessed residents with the comprehensive tool as indicated in the policy. The facility failed to monitor at risk residents as indicated on their individual service plans resulting in an apparent altercation, when Resident #2 wandered into Resident #1 ' s , 9:45 PM. Resident #1 was later found on the floor bloody with the bed sheets pulled off the bed Resident #2 standing over her. Class III	A 025		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Emeritus At Deer Creek
2403 West Hillsboro Blvd
Deerfield Beach, FL 33442

Dear Administrator:

Re: CCR #2012012070

This letter reports the findings of a state complaint survey that was conducted on , 2013 by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within **thirty (30) days** of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after **2013** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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 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 representative. Should you have any questions please call this office at 561-381-5840.

Sincerely,

for Arlene Mayo-Davis
Field Office Manager

AMD/dlt
Enclosure
XG90

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