STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964897	08/05/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Deer Creek	2403 West Hillsboro Blvd Deerfield Beach, FL 33442	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0007 - 58a-5.0181(1) Fac - Admissions - Criteria S-S= D
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:

0000-Initial Comments
An Assisted Living Facility complaint inspection survey (CCR# 2013002070) was conducted on . The Emeritus at Deer Creek had deficiencies found at the time of the visit.

0007-Admissions - Criteria 58A-5.0181(1) FAC

Based on interview and record review, the facility failed to follow the admission criteria. As evidenced by the admission of a resident who was bedridden, immobile and was totally dependent for all activities of daily living (ADLs), for 1 out of 3 sampled residents sampled (Resident #3).

The findings include:

Resident #3 was admitted to the facility on from another Assisted Living Facility with medical diagnosis of functional decline, change in mental status, with and history of . Review of the resident's Health Assessment (AHCA form 1823) dated revealed the resident requires medication administration by the nurse, and total assistance for all ADL care. The resident is . She is on a regular mechanical soft diet and is unable to feed herself. She has a contracted right arm.
Review of the facility Care Plan dated revealed the resident has total memory loss, severely . She requires total dependence for ADL care and assistance for mobility in wheelchair. She requires physical assist for transfers. The resident is documented as having no .

Review of the Nurses Notes dated documented the resident develops a stage on her right care treatment and a gel mattress is ordered by the physician. Review of the Physician note dated revealed the resident has on her . The is healing, showing some blanching and redness around the area. No open is seen, The resident gets full help with ADL care and medication supervision from the nursing staff. The residents daughter feeds her mother her meals with lots of cueing. The plan is for the resident to be turned and positioned as much as possible. and C are ordered daily for healing.

Review of physician order dated revealed " Non-blanchable reddened area right elbow, cleanse with Normal and apply Tegaderm Hydrocolloid dressing 2 times a week for 4 weeks' and on cleanse reddened area on sacrum with Normal and apply Tegaderm Hydrocolloid dressing daily " .

On at approximately 12:00 PM during an interview with the Care Nurse she stated that the resident has care treatments 2 times a week for on the residents right elbow and

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preventative treatment to the area after healed . She stated the resident is immobile, that she cannot move or position herself and that the resident has a of her right arm.

On at approximately 2:00 PM during an interview with the Resident Care Manager, she confirmed the resident had developed a on her right elbow and has continued treatment on the to prevent development of chronic She stated that the resident cannot move herself and she requires staff or her family to feed her meals. The Manager and surveyor observed the on the residents right elbow to be dime size 1 cm, 100% with brownish drainage noted on the dressing. The residents arm was edematous and was pinkish in color around the area. The Manager stated that the resident developed the from the wheelchair arm rest. Observation of the wheelchair revealed a padded cushion arm rest. The Manager agreed that the resident requires total ADL care, is unable to feed herself and immobile in bed requiring assistance to turn.

Class III

0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on observation, interview and record review, the facility failed to adequately provide care and services appropriative to the needs of the residents. As evidenced by facility failure to offer personal supervision to prevent monitor and assess for changes in condition,and implement interventions after repeat to promote safety and physical and emotional well being, for 1 out of 3 sampled residents (Resident #1).

The findings include:

Resident #1 was admitted to the facility Memory Care Unit on from a Skilled Nursing and Rehabilitation Center per request from the residents family. The resident is described by the rehabilitation center as alert and orient to person and place but forgetful. He was able to ambulate with supervision, needs total assistance with ADL care, needs assistance to transfer from sitting to standing and unable to transfer from toilet or tub per the discharge summary from the skilled nursing facility. The resident's Health Assessment (AHCA form 1823) dated , revealed the resident has ; and . He has generalized with limited movement to the lower extremities. He is described as , restless and possible elopement risk. precautions are advised for the resident. The resident requires supervision with ambulation and eating, and assistance with all other ADL care.

Review of the facility Initial Care Plan dated , revealed the resident is alert but totally , he does not know he is at the facility, cannot remember location of his requires constant cueing for directions. The resident is identified as having unsteady gait and using a walker. He requires total assistance with ADL care and standby assistance to and from the constant cueing for personal hygiene needs. The Ambulation and Mobility Evaluation completed on revealed the resident has intermittent , has had no in the last 3 months, gait /balance normal, and ambulatory for elimination but requires cueing.

Review of the Physician Note dated , the resident is described as having declining memory, with functional decline and . The resident has history of mood agitation and with and has been taking and . The physician recommends a consult for

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medication dose reduce due to observation of sedation. The resident is evaluated and the medication reduced to 0.5 mg in AM and 1 mg at bedtime also the was increase to 50 mg at bedtime. The Psychiatrist to follow and make adjustments to the medications as needed.

On , the resident was found on the floor. He states he and has pain on his right side. The resident is transferred to the ER for evaluation. The physician and family are notified. Review of the Nursing Notes from revealed, the resident returned to the facility with . He expresses no pain or discomfort upon his return.

On the physician visits the resident and describes the resident as more alert, talking more. The residents medications are adjusted due to low .

On the resident is found on the floor next to the elevator. He is alert but unable to describe how he per the nursing note. An is noted on the residents right shoulder. The physician and family are notified of the .
The Physician and Nursing notes from 2012 thru 2012 revealed the resident is seen monthly by the physician. The resident's is controlled, the medications for mood are monitored and the resident continues to require total assistance with ADL care with lots of reminders. The note dated documents the resident is ambulating fairly independently at this point but gets help with his ADL care.
On the resident is found in his the floor. He complains of pain in his right arm. The resident is sent to the ER for evaluation and the physician and family were notified. On the resident returns to the facility after sustaining a of the right arm. The arm is immobilized with a sling and monitored for circulation by the nursing staff. On the residents arm is observed to be and painful also the resident complains of a right hip which he is unable to move. His temperature is 101F and . The physician is notified and the resident is sent 911 to the ER for evaluation. The family was notified.

The resident is readmitted to the facility on after right hip repair s/p and right .
The resident is transferred from a rehabilitation center, and the rehabilitation summary revealed the resident had made progress. He is able to ambulate with rolling walker 120 feet with contact guarding. He requires ADL assistance and continues to be a safety risk/ risk. recommended grab bars. The resident has a right heel on readmission and care is ordered daily.

On , the Physician Progress note revealed the resident has had a increase in functional decline from . The resident has a right heel which the physician expresses concerns about healing, requiring possible consultation, care treatments are completed daily. The resident is considered a risk and he utilizes a lightweight wheelchair for mobility, since he is not ambulating much.
Review of the 1823 dated revealed the resident has a on his right heel. The resident requires total assistance with ADL care.

Review of the Care Plan dated , revealed the resident requires one person physical assist with transfers, uses a wheelchair for mobility. He requires check daily for management and needs assistance with continence needs. There is no documentation of care requirements on the care plan. There was no documentation of reassessment of risks and interventions to prevent further .
Review of the Nurses Notes on ,revealed the resident in the hit his head. A hematoma and laceration was noted to the residents forehead. The resident complained of pain in his head and neck. The resident was sent 911 to the ER for evaluation the physician and family were notified.

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Review of the facility Incident Sheet dated , revealed the aide assisted the resident to the toilet. The facility investigation determined that the resident had complained of head and stomach pains and had been assessed by the nurse. The resident expressed need to use the toilet to move his bowels and the aide took him to the . The aide stood outside the door and after 1 minute entered the check the resident. The resident stood up while holding his head and stating "my head hurts" and sideways hitting his head on . The report documents red drainage coming from the residents nose. Emergency 911 was called and the resident was transferred to the ER.

On at approximately 2:00 PM during an interview with the resident aide who regularly cared for the resident, she stated that at admission the resident was ambulatory, walked to the toilet and required assistance for personal care. She stated that the resident had a history of and had his hip and shoulder. She stated that when the resident was readmitted in 2013 after the injuries, the resident was unable to ambulate but used a wheelchair. She recalled that on at breakfast, the resident was complaining of pain in his head and had blurred vision. She stated that she notified the nurse who assessed the resident.

At lunchtime, she brought the resident to the dining . he continued to express that he had pain in his head and needed to move his bowels. She stated she assisted the resident to the employee to the dining . She stated that she helped the resident to the toilet and he continued to complain that his head hurt and he wanted to die. She stated that she instructed the resident " not to stand up but wait for her to enter so she could help him stand ". She then stepped out of the allow for privacy, approximately 30 seconds. She stated that she kept the door slightly opened so she could hear the resident. She recalled that she opened the the resident stated " my head hurts " and then he attempted to stand up from the toilet by himself. She stated the resident leaned sideways and on his side to the floor. She stated that " she could not catch him in time " . The aide started to cry and then continued that the resident was responsive after he . She stated he complained of neck pain and had a nose . She recalls he told her to " Get me up, get me up " She stated she yelled for help and the LPN came to assist her and 911 was called.

On at approximately 2:30 PM during an interview with the Resident Care Manager, she stated that the facility will update the care plan after resident . She reviewed the most current care plan and agreed that the resident had a history of and was a known risk requiring precautions. No evidence was provided that the facility had reassessed the resident's risk after each or discussed interventions to prevent and further injury with the family and physician. She stated that the residents are monitored to prevent .

On at approximately 3:00 PM with the Resident Care Manager and Administrator provided a copy of the ' One Day Report ' submitted to AHCA on . The report status was documented as incomplete. When questioned about the internal investigation of the incident to determine if the incident was an adverse incident and the completion of the 15 day report, they stated that they both were not on staff at the time of the incident. They stated that they could not locate the 15 day report or documentation that it had been submitted.

Review of the One Day Report on the AHCA website on at 3:30 PM, revealed the current status of the report was withdrawn by the facility. There was no documentation that the facility investigated to determined if the staff could have prevented the incident. The current posted status is incomplete.

Class II

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0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC

Based on record review and interview, the facility failed to adequately investigate a potential adverse incident and submit the required adverse incident report to the state, for 1 of 3 sampled records reviewed (Resident #1)

The findings include:

Resident #1 was admitted to the facility Memory Care Unit on [redacted] from a Skilled Nursing and Rehabilitation Center per request from the resident ' s family. The resident's Health Assessment (AHCA form 1823) dated [redacted], revealed the resident has [redacted] and [redacted]. He has generalized [redacted] with limited movement to the lower extremities. He is described as [redacted] restless and possible elopement risk. [redacted] precautions are advised for the resident. The resident required supervision with ambulation and eating, and assistance with all other ADL care.

Review of the facility Initial Care Plan dated [redacted], revealed the resident is alert but totally [redacted] he does not know he is at the facility, cannot remember location of his [redacted] requires constant cueing for directions. The resident is identified as having unsteady gait and using a walker. He requires total assistance with ADL care and standby assistance to and from the [redacted] constant cueing for personal hygiene needs.

Review of the Nurses Notes on [redacted] revealed the resident [redacted] in the [redacted] hit his head. A hematoma and laceration was noted to the residents forehead. The resident complained of pain in his head and neck. The resident was sent 911 to the ER for evaluation the physician and family were notified.

Review of the facility Incident Sheet dated [redacted], revealed the investigation documented on [redacted] that the resident had complained of head and stomach pains and had been assessed by the nurse. During the lunch meal ,the resident expressed the need to use the toilet to move his bowels and the aide took him to the [redacted]. The aide stood outside the door and after 1 minute entered the [redacted] check the resident. The resident stood up while holding his head and stating "my head hurts" and [redacted] sideways hitting his head on [redacted]. The report documents red drainage coming from the residents nose. Emergency 911 was called and the resident was transferred to the ER.

On [redacted] at approximately 3:00 PM with the Resident Care Manager and Administrator provided a copy of the ' One Day Report ' submitted to AHCA on [redacted]. The report status was documented as incomplete. When questioned about the internal investigation of the incident to determine if the incident was an adverse incident and the completion of the 15 day report, they stated that they both were not on staff at the time of the incident. They stated that they could not locate the 15 day report or documentation that it had been submitted.

Review of the One Day Report on the AHCA website on [redacted] at 3:30 PM, revealed the current status of the report was withdrawn by the facility. There was no documentation that the facility investigated to determined if the staff could have prevented the incident. The current posted status is incomplete.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2013

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

Re: CCR #2013002070

Dear Administrator:

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

Attached is the provider's copy of the State (5000-3547) 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 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/jw
Enclosure

XG90

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