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	AL11964897	09/13/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
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List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0092 - 58a-5.020(1) Fac - Food Service - General Responsibilities S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced Assisted Living Facility Biennial standard licensure survey with Limited Nursing Services was conducted on . . . . . Emeritus at Deer Creek had licensure deficiencies found at the time of the visit.

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 appropriate for the needs of the residents as evidenced by failure to: monitor and assess for changes in condition for a inserted central line , properly store and monitor . . . . . medications requiring refrigeration, document communication with the third party provider and follow physician orders for medication administration, to promote safety and physical and emotional well-being for 1 of 27 sampled residents, Resident #1.

The findings include:

Resident #1 was admitted to the facility on . . . . . with medical diagnosis of . . ,kidney stones, ... lumbar scoliosis, ... , and discs, ... chronic back pain.

The admission 1823 Resident Assessment form dated . . . . . reveals the resident ambulates with a walker, and requires supervision with her activities of daily living (ADL) care. She is documented as having . . . . . with . . . . . on.The resident requires assistance with self-administration of her medications. The facility Individualized Service Plan documents the resident as having . . . . . and has periods of forgetfulness and . . . . . .

On . . . . . at approximately 11:00AM, the resident was observed in her . . . . . A 3 inch . . tubing was observed dangling from her right upper arm/elbow. The resident was observed itching the skin around the dressing and pulling at the dressing and . . tubing. The adhesive tape around the dressing had been lifted and was soiled. The dressing covering the . . was marked " . . . . . with initials " . The resident stated she had been in the hospital but was unable to recall the dates or reason. Four large paper shopping bags filled with . . supplies (tubings, syringes, needles) and numerous bags of . . antiobiotics . . . . . 1GM/ 250ml NS dated . . . . . were also observed in the shopping bags. The resident stated that she had been getting . . . . . thru the . . line until recently. She stated the . . . . . were stopped because she developed a . . . .

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on her arms from the medication. She stated that she thought the Home Health nurse should be coming to change her dressing later in the day. The resident stated that other medications were stored in her . . . . . Six bags of , Invanz 50mg dated , were observed in the residents small food refrigerator. The plastic bag containing the medications was wet to the touch. The label on the outside of each bag showed to refrigerate medication as well as instructions for use. The resident stated that her refrigerator was not cooling properly and was leaking. A wet towel was on the floor under the refrigerator door. A bottle of oral medication was observed on the resident ' s night stand. The resident stated that " she takes the medication as she needs it for her back pain " .

On at approximately 11:00AM during a telephone interview with the Home Health office, the nurse answering, stated that the resident had gone to the . . . . . recently and the antiobiotic had been held, due to the development of a skin . . . . She stated that the resident is ordered to be seen for dressing changes by the Home Health Nurse, but she could not determine when the last dressing changed was completed.

On . . . . . at approximately 11:20PM during an interview with a staff Licensed Practical Nurse (LPN), she stated that medications that require refrigeration should be stored in the facility medication refrigerator, in which the temperature is monitored daily by the nursing staff. She stated she is not involved with the care or monitoring of Resident #1 ' s . . . . line.

Record review of the Medication Observation Record for 2013 reveals the resident is prescribed, 1% 2.5mg every day, inhaler every day, 25mg patch every 72 hours, ... 325mg/ 5mg 3 times a day as needed , 1 GM every day , and Invanz 500 mg every day.

Review of the facility Progress Notes reveals the last note was dated . . . . . No documentation was noted in the resident chart about the line, changes in orders for antiobiotic or development of the . . . . . No documentation was available indicating physician orders for the use or care. Review of the Limited Nursing Services(LNS) Log revealed the resident was not listed as receiving LNS by the facility.The facility was initially unable to locate a copy of the Home Health Certification and Plan of Care for the resident.

Review of the Home Health Certification and Plan of Care , provided by the Resident Care Director (RCD) on at 12:00PM , reveals the start of nursing care beginning on . . . . . thru . . . . . The resident's health prognosis is documented as fair, and mental status as oriented but forgetful. The written orders are for a Registered Nurse (RN) to visit 2 times a week for first week; 7 times a week for 2 weeks; once a week for 6 weeks and PRN 1-2 visits for any medical issue. The skilled nurse to administer and teach meds injections, and provide Normal . . . flush pre/post and flush 100u/ml 5 ml. Also complete dressing change per technique with . . . . . x3, . . . x3 and dressing applied.

On at approximately 11:30 AM during an interview with the Resident Care Director (RCD) she stated that she thought the resident had a history of kidney . . . . and chronic . . . . . She was not sure when the line had been inserted or for what reason. She stated that care of the . . . . would be considered a high risk potential for complications in the ALF setting and the line should be properly monitored.The RCD stated that she was aware that the resident was receiving Home Health services but was not aware the resident

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had experienced a . . . and the antiobiotics were being held. She stated that there had been no communication with the Home Health Nurse or physician regarding the medications or . . . . The RCD stated that the facility employs Licensed Practical Nurses who are scheduled daily from 7 AM to 11PM but they do not administer medications via the . . . . line or monitor the insertion site. She stated the Home Health Nurse handles the care of the . . . . line. The RCD stated that the facility does not have policy requiring the Home Health Nurse to report the daily care provided. She stated there was no " sign in " sheet for the Home Health personel indicating the date or time of the visit.She agreed the Home Health Nurse should report to the RCD, communicating care provided at the visit and proper documentation should be maintained and available to reflect the resident's medical status. She stated that medications requiring refrigeration should be properly maintained and monitored by appropriately trained staff. Also, she stated the resident should not have any medication stored in her . . . . I . . I be self- administering the medications without appropriate physician orders to do so. The RCD was unable to locate physician orders allowing the resident to self administer her medications.

On . . . . , at 4 PM during an interview with the Administrator ,he stated that he had been informed that the resident had a . . . . line and was receiving . . . . . medication treatment. He stated that the corporate nurse had approved the resident admission under the facility LNS license. He stated that he was not aware that the facility had not been documenting observations or monitoring the care being provided to the resident by the Home Health Agency. He agreed the resident should be appropriately monitored and care documented and communication between the facility and Home Health provider must improve immediately.
Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observations, record reviews and interviews the facility failed to honor the residents' right to live in a safe and decent living environment and be treated with respect and due recognition of personal privacy and dignity for all residents affecting 2 of 27 sampled residents (#2 and #3) and random residents.

The findings are:

1. On . . . . . at 1:30 p.m. in the nursing station, there was a resident observed receiving . . . . . treatment. The resident was seated in a chair in full view of the residents' records. In addition, there were two staff members in the immediate vicinity of the resident. The staff members were observed discussing other residents' personal health issues while on the phone and going about their business in front of the resident receiving the . . . . . treatment. The resident care director was interviewed on . . . . . at approximately 1:40 p.m. and confirmed the findings.

2) Call lights were not answered in a timely manner as observed on . . . . . for two residents (Resident #2 and #3). On . . . . . at 10:14 a.m., Resident #2's call light was tested and the resident pressed her call pendant at 10:21 a.m. By 10:35 a.m. no staff came to respond to the call light. In an interview conducted on . . . . . at 1:28 p.m., the Administrator stated that 20 minutes to wait for a call light response was, "too long."

Resident #3's call light was tested on . . . . at 11:14 a.m. and a resident aide came into the . . . . . 11:26 a.m., 12 minutes later.

In an interview conducted on . . . . . at 1:28 p.m., the issue with two grievances filed about call lights was

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brought to the Administrator's attention. One of the responses to a grievance was, "Will have Administrator pull up log and check on times when she (resident who filed grievance) pushed pedant." The Administrator stated that the facility had a recent in-service on call lights. A log was requested from the Administrator but he never produced it.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observations, interviews, and record review, the facility filed to ensure that assistance with self-administration protocols were followed for 3 (Resident #5, #6, and #22) out of 7 sampled residents for medication observation.

The Findings:

1) During a medication pass observed on at 9:55 a.m., Staff #6 crushed the following pills on the medication cart and later pointed to the Medication Observation Report that stated, crush pills." The following pills were crushed: 600 plus D 200, Dilitazem (120 mg), (7.5 mg, two tables), Fanotifine (20 mg), Extended Release (200 mg), and (1 mg). A record review revealed a physician's order to "crush medications," but did not specify which ones.

Staff #6 was observed entering resident's a souffle' cup and plastic bag of crushed pills and placing it on the kitchen table. She handled a dirty breakfast tray and placemat and did not wash her hands prior to giving Resident #22 her medications. Resident #6 stated she would keep the placemat but Staff #6 stated, "It's dirty and needs to be washed." Staff #6 poured the crushed medications into a soufflé cup and gave the medications mixed with applesauce per resident's request. Staff #6 did not tell the resident the names of any of the medications.

Staff #6 assisted Resident #22 with her inhaler 45 mcg) and waited only 20 seconds between pressing down for puffs. The directions for stated to wait 1 minute between puffs.

A total of 15 mg of should have been given to Resident #22 according to the Medication Observation Record. The bubble packet contained 7.5 mg tablets. Only 1 tablet (7.5 mg) was put into the soufflé cup by Staff #6. She put in another tablet equaling the proper dosage of 15 mg after the surveyor pointed this out to her.

2) Review of the clinical record of Resident #6 on revealed an admission date of with diagnoses that included It was noted that the resident leaves the facility three times per week on Tuesday, Thursday and Saturday from approximately 8 AM to 3 PM. During the review of current physician ordered medication and and Medication Observation Record (MOR) for and it was noted that there were missed doses of prescribed medications on days. The review revealed that the 1 PM scheduled dose of 10 mg (3 times per day) was documented on MOR's as not being administered on all days three times per week. Following the review the issues was discussed with the Resident Care Coordinator (LPN) on The nurse stated that she was unaware that the resident's 1 PM dose of was not being given on days (3 times per week) since admission. It was also discovered that the nurse was unaware that the resident's medication regimen should have been reviewed with the center upon admission to ensure the timeliness of medication administration on days and the effectiveness of medications on days and to obtain new physician ordered medication times. A review of

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the clinical record of R #6 on revealed that the facility still had not reviewed medications with the physician and obtained new medication time orders.

3) During the review of the clinical record of Resident #5 on an admission date of was noted with diagnoses that included It was revealed that the resident receives services three times per week on Tuesday, Thursday and Saturday. The resident leaves that facility at approximately 8 AM and returns to the facility at approximately 3 PM on these days. Review of the Medication Observation Records (MOR) for the months of 2013 and 2013 revealed documentation that the resident was refusing all 9 AM scheduled medications on days. The omitted 9 AM medications on days included; Bicarb 450mg 2 times per day Nephrocap Softgel 1 cap QD (daily) Pantioprozole DR 40 mg DR 30 mg (QD), Aibdarone 200mg (QD), and 25 mg Further review of the MOR's revealed documentation only that the resident refused all AM medications on days. Following the review the issues was discussed with the Resident Care Coordinator (LPN) on The LPN stated that the resident refused AM medications on because she was told by staff at the center that the morning medications would be dialyzed and ineffective. The nurse further stated that the center was not called to review the medications to confirm if the medications were dialyzed. It was further noted that the the facility LPN failed to contact the physician on admission to review all scheduled physician ordered medications for timeliness and effectiveness.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation and interviews conducted on and it was determined the facility failed to ensure that all prescription medications are kept in a locked unit or all times.

The findings include:

1. Observation of the medication storage on the first floor of the facility on at 10:30 AM and at 11:30 AM noted that the entry door was propped open and no facility staff were located within the Further observation of the a refrigerator labeled as "Medication Refrigerator" which was unlocked on both observations. An interview conducted with nursing staff following the observations revealed that the lock to the medication refrigerator has been missing for some time. It was also observed that the medication located within a central hallway and numerous residents including residents passed by the open A review of the contents of the medication refrigeration noted the following non-secured medications:

Levimer

Lantus

Novalog

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Injection.

Bravia

Bisculax Suppositories

2. On at 10:20 a.m. in 4 bags of supplies for and the themselves were observed in the plain view. The resident was interviewed (resident #1) and said she was in the hospital last week and was now waiting for someone to pick up the supplies. The resident also stated that the refrigerator in the not working properly.
On at 11:00 a.m. the resident care director accompanied the surveyors to the resident's observed the medications in the paper bags. There were also six bags of antiobiotic, Invanz 50mg dated observed in the resident's small unlocked food refrigerator. The plastic bag containing the medications was wet to the touch. The label on the outside of each bag showed to refrigerate medication as well as instructions for use. The resident stated that her refrigerator was not cooling properly and was leaking. Resident #1's record was reviewed and documented that the resident required assistance with medication.

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on record reviews, and interviews the facility failed to ensure that 3/6 employees (staff #2, #3, and #5) complete the Staff In-Service Training (Incidents Reporting Training) within 30 days of employment.

The findings include:

1. During review of the employees' records on at around 3:00 PM the following employee #2 did not have the required Incidents reporting training completed as required after 30 days of employment.

A verification interview with the Business Office Manager confirmed that the employee did not complete the trainings as of the time of the interview.

2) A record review conducted on revealed that Staff #3 and #5, who provide direct care to residents, did not have a minimum of 1 hour ttraining on reporting major and adverse incidents within 30 days of employment. An interview conducted on at approximately 11:00 a.m., the Business Office Manager confirmed that he could not find evidence of the training in either staff members' charts.
Class III

0092-Food Service - General Responsibilities 58A-5.020(1) FAC
Based on observation, interview and record review conduced on and it was determined that the Dietary Manager failed to provide therapeutic diets specifically thickened liquids for 4 (Residents #8, #13, #14, and #24) as ordered and fail**ed to perform duties in a safe and sanitary manner.**

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The findings include:

During the observation of the lunch meal in the dining at 12:15 it was noted that R #24 was served a Pureed Diet with Thin Liquids. Interviews conducted with facility staff revealed that the resident has some swallowing difficulties. Following the observation a review of the clinical record of R #24 was conducted on and it was noted a Vitas - Interdisciplinary Plan Of Care/Physician Orders dated A review of the orders revealed documentation of the following;

1) Symptoms

2) Maintain Precautions

3) Thicken Liquids to Nectar Consistency due to coughing with fluids

4) Provide and Instruct facility on

Further review of the clinical record revealed that the only updated diet order was a Vitas - Physician Orders dated that documented a Mechanical Soft Diet. The record did not contain documentation that the diet had been downgraded to pureed. Interview conducted with the Charge Nurse on concerning the issue revealed that she was unaware of the Vitas Physician Order for Nectar Thickened Liquids. The nurse stated that the facility's policy was not followed to ensure that all new changes in physician orders are to be copied and sent to the charge nurse to ensure that the orders are being followed.

2) During the review of the lunch meal on in the Memory care Unit and the back Dining was noted that R #8 ,R #13 and R #14 were served Nectar Thickened beverages that included water and juice with their lunch meals. Following the observation an interview with the Dietary Manager and review of the facility's diet census was conducted. The interview and review revealed only documentation of "Thickened Liquids" without and documentation of the level of thickness beverages were to be thickened (Nectar/Honey/Pudding). The Dietary Manager indicated that he was unaware that there were different levels of consistency that beverages are thickened to and did not seek clarification of physician orders. An interview with the charge nurse was also conducted on and it was revealed that there were orders for thickened liquids, however, a clarification with the physician or Speech was not obtained.

3) During the kitchen/food service sanitation tour conducted on at 9:30 AM it was revealed that it could not be determined if the facility was sanitizing food preparation equipment and food preparation and serving surfaces as per regulatory requirement. Specifically based on interview with the Dietary Manager the test strips being used to test the Quatinary Sanitizer in the 3-Compartment Sink and the cleaning rag buckets (3) were the incorrect strips. The strips that were being utilized were for a different chemical sanitizer and would give a false test. On the Dietary Manager notified the surveyor that the chemical company that services the ALF confirmed that the test strips being used were incorrect.

Class III

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

Based on observation, interview and record review conducted on , it was determined that the nutritional

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needs of the residents were not being met that included the failure to follow documented portion sizes, and to follow the approved menu for regular and mechanically altered diets for 4 sampled residents (#7, #8, #13, #14) and other residents on mechanically altered diets and/or eating in the memory care units.

The findings include:

During the observation of the lunch meal on . . . . . at 11:30 AM it was noted that the approved menu for Regular Diets, Pureed Diets, and mechanically Altered Diets was not being followed as per the following:

1) During the review of the approved menu for the ,lunch meal on . . . . . it was noted that the regular menu included a #8 scoop (4 ounces) of Baked Beans and #8 scoop (4 ounces) of Corn Medley. An observation of the lunch tray line in the Main Kitchen on . . . . . revealed that a #6 scoop of Baked beans and #16 scoop of Corn Medley were being served. Interview with the Dietary Manager at the time of the observation revealed that dietary staff failed to review and follow portions during the service of the . . . . . lunch meals.

2) During the observation of the lunch meal in the Memory Care Units (#1 & #2) on . . . . . it was noted that the menu and nutritional needs for residents on Pureed Diets were not being meet that included R # 7 and R #8. Specifically a review of the menu revealed that the following menu items were not served; pureed turkey noodle soup, purred seasoned yellow squash, pureed pureed green beans, pureed baked beans, pureed or slurried bread, and milk. Interview with the Dietary Manager at the time of the observation revealed that staff were unaware of the therapeutic and mechanically altered diet extensions listed on the approved lunch menu.

3) During the observation of the lunch meal in #2 Memory Care Unit on . . . . . it was noted that the only nectar thickened beverages were nectar thick apple juice, nectar thick water, and lemon thick water. Interview with the charge nurse at the time of the observation revealed that nectar thick milk is not purchased by the facility. Further interview revealed that no milk portions or milk portion equivalent are being served that residents requiring thickened liquids. The nutritional needs is not being met for 16 ounces of milk or equivalent on a daily basis. It was also revealed that R #13 and R #14 had physician ordered thickened liquids.

4) During the observation of the lunch meal in the second floor Memory Care Unit on . . . . . it was noted that steam table foods that included the pork, vegetables, and baked beans were not being served by the use of portioning control equipment and the portion documented on the approved lunch menu. Staff were noted to be using only large preparation spoons and a guesstimate was being used for the food portions

Class III

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC
Based on observations, interviews, and record, review, the facility failed to ensure that it provided a safe living environment free of hazards for all residents.

The Findings:

1) During tours of the facility on . . . . . and . . . . . the following was observed:

a) Refuse closet on first floor, east wing, had unopened bags of trash, odors, and no lids on trash containers.
b) Refuse closet on second floor, east wing, had two trash containers with no lids and an adult diaper lying on the floor next to the trash bin.
c) Refuse closets on third floor, east and west wings, were piled with trash with no lid covers on containers.

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Trash bags were not all tied and latex gloves, styrofoam cups, and other trash was found on the floor next to container. .

d) Storage closet on second floor, east wing, had a small filled trash bag stored behind a rolled-up carpet.

e) Storage closet on third floor, east wing, had vases and furniture stored along with a storage crate with an empty coke can and other trash.

f) Storage closet on fourth floor, west wing, had a chandelier stored and a three-quarters filled trash can with no lid.

In an interview conducted on at 1:28 p.m., the Administrator stated he wasn't aware of any sanitation issues and that the storage closets are typically locked.

2) During an interview with resident # 10 at 11:30 am on , 2013, roaches were observed roaming over her banana and mix-fruits container, as well as on her bedside table. Subsequent to that observation, the resident was interviewed and said "I have roaches all the time in my . She continued and said that the pest control representative was here about three times during this month, but the problem still persists. She also said that there are more of them (roaches) in the . in under her kitchen cabinet. A look inside the cabinets confirmed her claim, and many roaches were seen inside the cabinets.

During a follow-up interview with the Administrator on at 1:36 PM, he confirmed that he is aware of the roaches ' infestation in the building. However, he stated that he has been actively trying to get rid of them. He continued and said that the Pest Control Agency which he has contracted with comes in every time they are called. However, they only spray the . He also pointed out that the pest control tech advised them to change the water drain covers in the . insinuating that the roaches appear to be coming out from there.

Review of the pest control visit log at 1:42 PM reveals that the facility has been having roach infestation since 2010. And many residents and staff have complained and reported the problem. The Administrator was asked: How do you ensure that the method used by the pest control company is effective? He replied " we have been looking to seek alternate services". As of the date of this survey the facility failed to ensure that the facility is free of pests (roach).

3) On at 10:15 a.m. on the 2nd floor, in an alcove directly outside there was an observation of 2 large open trash bags of construction debris, an open large bucket with remnants of adhesive in the bottom, with a soda can in the bucket and several rolls of baseboard material. On at 11:00 a.m. the resident care director observed the items, and upon interview stated that the items should not have been left there.

4) On at 11:15 a.m. in the memory care unit 2nd floor dining area, the legs of the dining tables and the chair legs were observed to be heavily soiled. The director of the memorty care unit was interviewed on at 11:20 a.m. and said the furniture would be replaced.

5) During the review of the Medication Storage/Nursing Office on at 11 AM it was noted that there was not a safe environment. Specifically the carpeting was heavily stained and worn throughout the It was also noted that there were numerous large areas of black, thick stains that appeared to be possibly caused by some

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type of spillages. The portable privacy screen was also noted to have numerous and large brown/reddish stains. Large and overflowing uncovered trash containers (2) were noted to be stored directly near medication carts and resident treatment chairs. During the observation it was noted that numerous resident receive medications in the , receive ointments to skin areas, and have and injections within the The administrator was interviewed and observed the at 11 AM and confirmed the findings.

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: Relicensure Survey

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,

Arlene Mayo - Davis
Field Office Manager

AMD/jw
Enclosure
XG90

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone (561) 381-5840; Fax (561) 496-5924