STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932698	12/23/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Park Summit At Coral Springs	8500 Royal Palm Blvd Coral Springs, FL 33065	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - N278 - 58a-5.031(3) Fac - Lns - Records S-S= D

Specific Tag Findings:

0000-Initial Comments
An Assisted Living Facility standard biennial licensure survey with Limited Nursing Services (LNS) was conducted on . Park Summit at Coral Springs had licensure deficiencies found at the time of the visit.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation and interview, the facility's Licensed Practical Nurse (LPN) failed to ensure staff implemented and maintained control practices during sugar glucometer checks and during medication pass for 5 of 5 residents observed during medication pass (Residents #6, #8, #9, #10 and #11).

The findings include:

On at 11:55 AM, an interview was conducted with the LPN assisting residents with the administration of medications in the Wellness stated she has worked in the facility for 10 years.

a) On at 12:00 PM, medication pass was observed with the LPN and Resident #8. The LPN was observed to don a pair of gloves and perform a sugar glucometer check on Resident #8. After the test was completed she proceeded to the Medication Observation Record (MOR) and with her gloves still on flip through the pages. She then took her gloves off and went to the fridge to retrieve a vial of She donned a new pair of gloves without washing her hands first. She prepared the syringe and administered the to Resident #8. She took her gloves off and flipped through the MOR, opened the medication cart drawer and took out a pill pack, popped the medication into a medication cup and with her bare fingers held the cup with her index finger inside the rim of the cup and handed the medication cup to the resident. The LPN then washed her hands.

b) On at 12:07 PM, Resident #9 came into the Wellness sat down. The LPN was observed to don a pair of gloves and perform a sugar glucometer check. After the

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test was completed she proceeded to retrieve the from the medication cart with her gloves still on. She then took her gloves off and checked the MOR. She donned a new pair of gloves and prepared the syringe and administered the to Resident #9. She took her gloves off, opened the medication cart drawer and took out a pill pack, popped the medication into a medication cup and with her bare fingers held the cup with her index finger inside the rim of the cup and handed the medication cup to the resident. At no point during or after the medication pass did she wash or sanitize her hands.

c) On at 12:18 PM, Resident #10 entered the Wellness her medications. The LPN, who after performing a test with Resident #9 and preparing her medications did not wash or sanitize her hands before preparing Resident #10's medication. The LPN was observed to open the medication cart drawer, retrieve the medication, pour it into a medication cup and with her bare fingers held the cup with her index finger inside the rim of the cup and handed the medication cup to Resident #10.

d) On at 12:28 PM, Resident #11 entered the Wellness her medications. The LPN was in the process of making copies of a chart. The LPN was observed to not have washed or sanitized her hands since completing the medication pass with Resident #8 at 12:00 PM. The LPN was observed to open the medication cart drawer, retrieve the medication, pour it into a medication cup and with her index finger inside the medication cup handed it to Resident #11. After assisting Resident #11 with her medication the LPN was observed to go over to the wall mounted hand sanitizer next to the medication cart and sanitized her hands. She was then observed to continue to make copies of a chart.

e) On at 12:32 PM, Resident #6 entered the Wellness sat down. The LPN was observed to use the hand sanitizer, open the medication cart, prepare the medication and with her index finger inside the medication cup handed it to Resident #6. The LPN was then observed to assist the resident with her walker, placing it in front of her for easy access. The LPN then signed off the MOR and put the medication back into the medication cart. She then went to the desk and started shuffling through some papers. The LPN did not wash or sanitize her hands after assisting Resident #6 with her medications and walker.

Class III

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N278-LNS - Records 58A-5.031(3) FAC

Based on observation, interview and record review, the facility failed to ensure documentation of assessments and progress notes were completed, for 2 of 2 sampled residents receiving Limited Nursing Services (LNS) (Residents #3 and #4).

The findings include:

On [redacted] at 9:15 AM, an interview was conducted with the facility ' s Administrator who stated they currently have 2 residents, Resident #3 and #4, under LNS for [redacted] Wrap bandages to lower extremities daily.

1) Resident #3 was admitted to the facility on [redacted] with diagnoses to include history of [redacted] hip, [redacted] and [redacted] Review of the LNS Log revealed Resident #3 was admitted to LNS services on [redacted] Review of the record revealed a physician order dated [redacted] to apply [redacted] Wrap to [redacted] lower extremities daily and remove at bedtime. Further review of the record revealed no evidence of an initial assessment by the LNS Supervisor related to the [redacted] lower extremity [redacted] or evidence of documentation of the ongoing status of Resident #3's [redacted] lower extremities.

Review of the Limited Nursing Progress Notes dated [redacted] through [redacted] revealed the nursing service to be provided is applying [redacted] wrap daily to [redacted] lower extremities for lower extremity [redacted] with the desired outcome to be 'lower [redacted] to [redacted] lower extremities'. Further review of the LNS progress notes revealed the Licensed Practical Nurse (LPN) is signing off under the progress section the [redacted] Wraps were applied on the 7 AM-3 PM shift and removed on the 3 PM -11 PM shift. However, there is no evidence of documentation of the status or condition of the resident's [redacted] lower extremities. Review of the Progress section of the notes details the nurse to ' include general status of resident's health and whether meeting goals. '

On [redacted] at 9:55 AM, observation was made of the LPN applying the [redacted] Wrap bandages to Resident #3's [redacted] lower extremities. An interview was conducted with Resident #3 at 10:00 AM, who stated the bandages help with her mobility. Although, she has some pain and she believes the [redacted] is going down. On [redacted] at 11:00 AM, an interview was conducted with the LPN who confirmed they do not document the status of the resident's leg [redacted] they only sign off that the bandages were applied and removed.

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Review of the record revealed a Monthly Assessment dated [redacted] documenting the resident's overall skin condition is 'dry and intact.' There is no evidence of documentation related to the resident's [redacted] lower extremity [redacted] and the application of the [redacted] Wrap bandages.
Review of the clinical record revealed a Monthly Assessment dated [redacted] documenting the resident's overall skin condition as 'intact, fragile.' There is no evidence of documentation related to the resident's [redacted] lower extremity [redacted] and the application of the [redacted] Wrap bandages.

Review of the facility policy for Limited Nursing Services Authorized Procedures documents 'A facility with a limited nursing license may provide the following nursing services in addition to any nursing service permitted under a standard license, to include, Application of [redacted] wrap bandage.'

Review of the facility policy for Limited Nursing Services Documentation Requirements states in part, 'A written up to date progress report on each resident receiving nursing services will be maintained. This progress report will be written at the time the procedure is performed to keep information current. It shall describe the 1) Type of nursing service; 2)Duration of the service; 3) Amount of service; 4) Scope of service; 5) General status of the resident's health; 6) Desired outcome of the services that are rendered; 7) Whether residents are meeting Limited Nursing goals and making progress. A nursing assessment of the residents receiving nursing services will be performed at least monthly and recorded on monthly summary.'

An additional review of the record revealed a physician order dated [redacted] to apply [redacted] medicated cream twice daily for a neck [redacted] until healed. Review of the Resident Service Notes revealed no evidence of an initial assessment or further documentation of the status of the resident's neck [redacted] Review of the [redacted] and [redacted] 2013 Medication Observation Record revealed the cream is being applied at 9 AM and 5 PM, on [redacted] at 12:21 PM, an interview was conducted with the LPN who stated Resident #3 was complaining of a [redacted] to her neck and the dermatologist ordered some cream. The LPN stated the [redacted] looks a little better and the cream was working however the resident was still complaining of itchiness. The LPN confirmed they did not document an initial assessment or any further documentation of the status of Resident #3's neck [redacted]

2) Resident #4 was admitted to the facility on [redacted] with diagnoses to include [redacted] and [redacted].

Review of the LNS Log revealed Resident #4 was admitted to LNS services on [redacted] Review of the Resident Service Notes dated [redacted] document 'Resident presents with [redacted] to [redacted] lower extremities. Physician notified, new order apply [redacted] Wrap to [redacted] lower extremities daily and remove at bedtime.'

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Further review of the record revealed a physician order dated , to apply Wrap to lower extremities daily and remove at bedtime. Additional review of the record revealed no evidence of an initial assessment by the LNS Supervisor related to the lower extremity or evidence of documentation of the ongoing status of Resident #4's lower extremities. Review of the Limited Nursing Progress Notes dated through revealed the nursing service to be provided; applying wrap daily to lower extremities daily for lower extremity with the desired outcome to be 'decrease to lower extremities'. Further review of the LNS progress notes revealed the Licensed Practical Nurse (LPN) is signing off under the progress section. The Wraps were applied on the 7 AM -3 PM shift and removed on the 3 PM -11 PM shift. However, there is no evidence of documentation of the status or condition of the resident's lower extremities.

On at 9:35 AM, observation was made of the LPN applying the Wrap bandages to Resident #4's lower extremities. An interview was conducted with Resident #4 at 9:40 AM, who stated she has leg pain and the bandages help with the pain and makes it easier for her to get around. On at 11:00 AM, an interview was conducted with the LPN who confirmed they do not document the status of the resident's leg , they only sign off that the bandages were applied and removed.

Review of the record revealed a Monthly Assessment dated documenting the resident's overall skin condition is 'dry, in lower extremities.' There is no evidence of documentation related to the application of the Wrap bandages or the status and condition of the to the lower extremities. Further review of the record on revealed no monthly assessment of Resident #4 for the month of

On at 11:00 AM, an interview was conducted with the Administrator who concurred they should have an initial baseline assessment of the resident's leg to determine if the bandages are effective or not.

Class III

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AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Park Summit At Coral Springs
8500 Royal Palm Blvd
Coral Springs, FL 33065

Dear Administrator:

This letter reports the findings of a state licensure survey with Limited Nursing Services (LNS) that was conducted on , 2013 by representatives 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 (30) days** of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after **2014** 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 representatives. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

J. Mayo-Davis, Arlene

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure: State form 5000-3547
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