STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963865	02/06/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Springtree	4201 Springtree Drive Sunrise, FL 33351	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D

Specific Tag Findings:

0000-Initial Comments
Unannounced complaint surveys (CCR #2013013233, #2013011387, # 2013009839, #2013011261, #2013009379 and #2013013147) were conducted on at Emeritus at Springtree Assisted Living Facility. The facility had deficiencies found at the time of the visit.

Deficient practice identifed at the following:
CCR # 2013009839 at A0054
CCR #2013013233 at A0025
CCR #2013011387 at A0010

0010-Admissions - Continued Residency 58A-5.0181(4) FAC

Based on observation,interview and record review, the facility failed to ensure the Resident Health Assessment form (AHCA Form 1823) was completed upon a significant change and reflective of the resident's current health status and care needs, for 1 out of 3 sampled residents (Resident #1).

The findings include:

Resident #1 was admitted to facility on with medical diagnosis of type with lower extremity right knee pain, hard of hearing, unsteady gait, and The Health Assessment form dated reveals the resident is alert with forgetfulness and requires redirection. Further review of the form revealed the resident requires assistance with medications and precautions. The resident is documented as independent for all ADL care.

Review of the Physician Order dated documents the resident is administered 20 mg

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every day, 25 mg every day, 200 mg every day , and 15 mg every night. Review of Medication Observation Record (MORs) for 2013 reveals the resident was administered medications as ordered by the physician.

On at approximately 10:15 AM during an interview with the Memory Care Director, she stated that the resident had been admitted to the Memory Care Unit due to increased behaviors including wandering, when ambulating within the facility and getting lost.She stated that the resident would wander into other residents and eat their food. She stated that the resident adapted very well to the unit, due to the much smaller size and freedom to safely wander within the closed unit.

Review of the facility Service Notes reveals no documentation of behaviors exhibited by the resident which would warrant the resident to be moved from the main Assisted Living section to the Memory Care Unit. Furthermore, there was no documentation from until when the resident is documented as falling in her injuring her hip.

Further review of the most current 1823 form revealed the form did not accurately reflect the current or behavioral status or nursing/ treatment service requirements for the resident since her identified change in mental status.

During an interview conducted with the Executive Director on at approximately 12:30 PM, she reviewed the resident record and stated that the resident had been moved to the Memory Care Unit on . She reviewed the 1823 Resident Health Assessment form and agreed that the form did not accurately reflect the status and facility oversight for the resident.

Class III

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

Based on observation,interview and record review, the facility failed to ensure resident records accurately reflect the current health status/condition and care needs for 2 out of 3 sampled residents (Resident #2 and #4). As evidenced by lack of documentation for the assessment, monitoring and follow-up with the physician about skin conditions for Resident # 2 and #4.

The findings include:

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A) Resident #2 was admitted on [redacted] with medical diagnosis of [redacted], weight loss, [redacted] and [redacted]. The Resident Health Assessment Form (AHCA Form 1823) dated [redacted] revealed the resident is alert and oriented, she ambulates with a walker and wheelchair for long distances. She has a history of [redacted] and requires assistance with ADL care and medication management. The resident is assessed to have poor sensory perception, she is hard of hearing. She has difficulty with balance when standing and walking. She requires one person assist with bathing/g

Review of the facility Service Notes dated [redacted] reveals the resident is seen by the Dermatologist and orders are written on [redacted] for [redacted] cream to trunk twice a day for 2 weeks. Record review revealed no documentation is noted prior to this note, indicating any symptoms or nursing assessment completed to request the visit.

Review of the Physician Order dated [redacted] revealed [redacted] cream to trunk twice a day until healed. Further review of the Service Notes after [redacted] revealed no documentation regarding the observation of the [redacted] with prescribed treatment.

Review of the Medication Observation Record for [redacted] 2013 and [redacted] 2014 revealed the resident is administered the [redacted] cream to the trunk twice a day by the nursing staff.

Review of the [redacted] Report dated [redacted] revealed the skin specimen was taken from the right leg by the Dermatologist, to rule out [redacted] versus drug reaction versus contact [redacted]. The diagnosis reported was subacute spongiotic

On [redacted] at approximately 11:45 AM an observation was conducted, along with the Resident Care Director, of the residents skin. The resident was observed sitting in her recliner chair, there were scabs and dried skin on her exposed upper and lower extremities. She stated that she had a [redacted] which was very itchy, on her trunk, arms and upper legs, also on her back and bottom. As the resident stood, she was unsteady, and lowered her pants, numerous dry pink scabs and excoriated areas on her [redacted] and back were noted; numerous tiny pink spots were noted across the resident's entire trunk and upper arms and legs with dry scaly patches. The resident stated that the spots were very itchy and she had been applying [redacted] Cream to the spots for relief. The Resident Care Director was unaware the resident was self medicating herself.

An interview was conducted with the LPN Wellness Care Coordinator on [redacted] at approximately 1:00 PM, she reviewed the record and confirmed there was no documentation about the

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skin condition of the resident which required a Dermatologist visit. She agreed that a nurse should be documentation in the Service Note describing the skin condition. She confirmed the nurses were applying the cream but they had not documented the description of the or improvement since the cream was applied. She stated that she was unaware that a had been obtained by the Dermatologist and she had not followed up with the results.

On at approximately 12:15 PM during a phone interview with the resident's family member, she was questioned if the resident had a prior history of skin conditions. She stated that she was unaware of any prior skin issues. But she stated that she had requested a Dermatologist appointment because she had noted numerous red spots on the resident body, along with itching. She stated that she had informed a nurse in the Wellness Center about the residents skin condition. She stated that she had not yet heard back anything about the physician visit.

On at approximately 2:00 PM during an interview with the Resident Care Director, she reviewed the medical record and stated that the nurse should document an initial skin assessment and document daily observations of the skin condition while prescribed treatment is in progress.

B) On at 9:00 AM, Resident #4 was observed by two surveyors, seated outside the main entrance on a bench. She was wearing a short-sleeved shirt and her arms and neck were exposed. The resident was scratching the area under her neck and a visible with redness was visibly noted. Upon further investigation, a , characteristic of scattered, red bumps was observed on both her arms. When the resident was asked about the , she voluntarily lifted up a portion of her shirt to show an area on her abdomen where the was also apparent. She expressed she was experiencing itching. Scabbed areas were also seen on her arms, scattered along with the active

Review of the resident's record revealed she was admitted to the facility on , with diagnosis of , and Memory Loss. The resident's most recent Health Assessment Form (AHCA Form 1823) dated noted she was forgetful, and needed supervision with bathing. An entry in the nurse's notes dated written by the Wellness Coordinator/Nurse, documented "Resident c/o itching to body; noted to body." The resident was also noted to have been experiencing and pain to her left foot. The note documented the physician was notified and requested the resident transferred to the hospital for evaluation. She was sent to the hospital on resident returned with a diagnosis of a foot and orders for pain medication. There was no evidence the was evaluated. There was no evidence in the medical record the facility followed up on the post the initial identification on . An interview was conducted with the Resident Care Coordinator (RCC) on at 12:24 PM. She confirmed the

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had not been monitored and measures for the care of the and itching had not been established. An interview with the Wellness Coordinator/Nurse was conducted on at 12:45 PM. She acknowledged the was not being monitored and there was no follow up after the was identified. She expressed to the surveyor, "It was an oversight." She stated she was going to call the resident's physician after the interview.

The resident was observed throughout the survey on and ambulating independently in the halls and seated amongst others residents in the main lobby and common areas. She was noted to scratch her head and arms at times. On at 12:00 PM, she was observed ambulating out the main lobby door and scratching her head. On at 12:00 PM, she was observed seated on a bench outside the main lobby door, and aggressively scratching her right arm to the point red line marks were made. On at approximately 2:30 PM, another surveyor noted the resident scratching her left area and expressed she was experiencing itching on the areas of her upper back and thighs.

On at 2:00 PM, the surveyor asked the Wellness Coordinator/Nurse if any measures were in place for the resident. She expressed the resident was sent in the afternoon on , to her physician and he gave orders for an pill "as needed", and a cream for itch relief, "as needed". She expressed the facility could not administer anything to the resident, until the physician changed the orders to routine as opposed to "as needed." She stated she was waiting on the physician to return a call and was going to ask the physician to order the medications for three days and then discontinue. She did not explain her rationale for discontinuing after three days. An interview was conducted with the RCC on at 2:10 PM, who stated the orders were sent to the pharmacy. However the pill and cream had not been supplied. The RCC stated a nurse was allowed to administer "as needed" medications and creams. She expressed she did not understand any rationale as to why the orders would be discontinued in three days. The issues were brought to the attention of the Administrator and on at 3:00 PM, she validated the lack of follow through for the and surveyor concerns.

Class III

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

Based on observation, interview and record review, the facility failed to ensure the Medication Observation Record (MOR) was properly maintained and updated. As evidenced by the failure to accurately document medications that were prescribed, for 1 of 3 sampled residents (Resident #3).

The findings include:

Resident #3 was admitted to facility on with , hard of hearing, , and s/p hip . Review of the Resident Health Assessment form dated revealed the resident is alert and oriented, but forgetful. The resident requires assistance with ADL care but independent for ambulation, eating, self- care and transfers. The resident requires assistance with self -administration of medications. Review of the facility individualized Service Plan on admission revealed the resident has alert, oriented with forgetful memory and having .

Review of the 2013 and 2013 Medication Observation Record (MOR) revealed the resident was prescribed 40 mg at 8 PM every day and 15 mg at 10 PM every day.

Review of the facility "Event Management" log dated reveals the resident called the Wellness Center requesting her bedtime meds. The form documents the Medication Technician (Med Tech) went to the resident 's gave the resident her the 8 PM The resident stated that it was the incorrect medication. The Med Tech told the resident it was the bedtime medication. The Med Tech did not dispense the tablet which was ordered for 10 PM, but initialed she had assisted with self administration on the Medication Observation Record (MOR). The was not initialed as dispensed by the Med Tech. Record review of the facility Service Notes revealed no documentation of the event on .

On at 12:30 PM during an interview with the LPN, working the evening shift on she stated that she recalled the resident calling the Wellness Center around 8 PM and stated that she was refusing to take the pill given to her. She stated that the resident requested her sleeping pill . The LPN recalls asking the Med Tech to administer the . She recalls at around 10 PM (end of the shift) the Med Tech informed her, that the resident had been administered the already. The LPN stated that she recalls the resident refused the and brought the pill to the Wellness Center the following morning.

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On ... at approximately 2:30 PM during an interview with LPN, working the day shift on , she stated that she recalled the resident came to the Wellness Center with the ... medication tablet, that the resident had refused to take from the previous night. She stated that she compared the tablet to the other ... tablets ordered for the resident. She stated she informed the resident that the tablet was indeed , not a sleeping pill (as physician order), ...

During interview with Executive Director (ED) on ... at approximately 3:00 PM, she stated that the Med Tech involved with the incident, no longer works at the facility. The ED stated that the employee was removed from resident care/ medication cart cart on and an investigation was conducted. She stated the investigation revealed that the Med Tech brought the ... dose to the resident's ... 8 PM. The resident questioned the accuracy of the medication provided and called the Wellness Center to inquire why she did not get her " other medication " at the same time. The Administrator stated the Med Tech told the resident she received the " night medication " . The resident insisted that she had received an incorrect evening medication. The resident refused to take the ... because the color of the pill was incorrect. The Administrator stated that the Med Tech gave the resident the ... tablet but she documented that she gave instead. The MOR did not reflect that the resident had refused the ... medication. She stated the resident ' s family was notified of the incident as well as the physician.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Emeritus At Springtree
4201 Springtree Drive
Sunrise, FL 33351

Re: CCR #2013009379, #2013009839,
#2013011261,#2013011387,#2013013147, and
#2013013233

Dear Administrator:

This letter reports the findings of Complaint State Licensure Surveys that was conducted on , 2014 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 **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 representative. Should you have any questions please call this office at (561) 381 - 5840.

Sincerely,

Arlene Mayo - Davis
Field Office Manager

AMD/jw
Enclosure

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