

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 03/06/2014
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11964897	(X3) DATE SURVEY COMPLETED 02/18/2014
NAME OF PROVIDER OR SUPPLIER Emeritus At Deer Creek	STREET ADDRESS, CITY, STATE, ZIP CODE 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 - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D

St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced Complaint Survey, (CCR#2013011050 and CCR#2013011953) was conducted at Emeritus at Deercreek Assisted Living Facility on ... through ... The facility had licensure deficiencies identified at the time of the visit. Deficient practice identified at CCR#2013011953 at A 0054 and A 0056.

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

Based on interview and record review, the facility failed to ensure physician medication orders were followed for 4 of 4 sampled residents reviewed for medication administration, Resident #1, Resident #2, Resident #3 and Resident #4; and failed to ensure the accurate documentation of medication on the Medication Observation Record (MOR) for 1 of 4 sampled residents, Resident #4.

The findings include:

1) Resident #1 was admitted to the facility on ... with diagnoses to include ... and ... with legal ...

Review of the record revealed a physician order dated ... for ... D3 50,000 units one cap by mouth weekly on Mondays.

Review of the ... 2013 MOR revealed the ... D3 was documented as being administered on 11/01, 11/02, ... and on Monday 11 ... and not once a week on Mondays as ordered. Subsequent doses were administered on Monday ... and Monday ...

On ... at approximately 4:00 p.m. the Director of Nurses and corporate Quality and Risk ... could not comment on why the medication was given daily and not on Mondays as ordered.

2) Resident #2 was admitted to the facility on ... with diagnoses to include ... and ...

Review of the record revealed a physician order dated ... to increase the ... (anti-ps ...

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medication) to 50 mg at bedtime for 5 days, then increase the dose to 62.5 mg at bedtime.

Review of the 2013 MOR revealed a hand written entry dated stating '50 mg at bedtime for 5 days, (then) in brackets' in the box below documenting the order for 62.5 mg at bedtime after the 5 days of the 50 mg dose.

Further review of the 2013 MOR revealed the 50 mg dose at 9 p.m. is signed off as being administered in addition the 62.5 mg dose of is also signed off as being administered concurrently at 9 p.m. The resident was receiving 112.5 mg of at bedtime and not the 50 mg for 5 days and then the increased dose of 62.5 mg thereafter. Resident #2 received 112.5 mg of up to and including Review of the record revealed a physician order dated stating 'increase from 62.5 mg at bedtime to 75 mg at bedtime.' There is no evidence of documentation the physician was notified the resident was receiving 112.5 mg of and not the 62.5 mg that was ordered by the physician on to commence on after the 5 days of the 50 mg dosage.

Further review of the record revealed a physician order dated stating 'Change (stool softener) to 100 mg (2 times daily) and not PRN (as needed).'

Review of the 2013 MOR revealed a hand written notation dated documenting 100 mg once daily at dinner time' and not 2 times daily as ordered on Documentation on the 2013 MOR reveals the order was signed off as being administered once daily at 5 P.M. from through and not twice daily as ordered.

Further review of the record revealed a physician order to change the from twice daily to once daily as of

Further review of the 2013 MOR and 2013 MOR reveal the order for the PRN continues to be documented although it was ordered to be discontinued on Additionally, the pharmacy computer generated MOR for 2013 continued to document the twice a day order that was discontinued on with a hand written notation stating 'Rewritten'. The 2013 pharmacy computer generated MOR did not reflect the new physician order for the which was changed on

3) Resident #3 was admitted to the facility on with diagnoses to include and back pain.

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Review of the 2014 MOR revealed the resident was taking _____ mg (pain medication) 3 times daily as of _____.

Review of the record revealed a physician order dated _____ decreasing the _____ mg tablets from 3 times daily to twice a day routinely.

Review of the 2014 MOR revealed the _____ continued to be administered 3 times daily up to and including _____ and not twice daily as ordered on _____.

Review of the 2014 MOR revealed the _____ continued to be administered 3 times daily and not twice daily as ordered on _____ up to and including a dose given on _____ at 2 p.m.

On _____ at approximately 4:00 P.M., the Director of Nurses stated she cannot comment on why the order was not carried out and she would have to review the records before she could comment.

4) Resident #4 was admitted to the facility on _____ with diagnoses to include _____ and _____.

Review of the record revealed a physician order dated _____ to discontinue the medications _____ (a _____ which depletes _____ stores in the body) and _____ (a _____ supplement which replaces the _____ depleted from the use of _____). Review of the 2013 MOR revealed the order for _____ 40 milligrams (mg) daily was documented with a hand written notation as discontinued on _____. Further review of the 2013 MOR revealed the _____ 10 milliequivalents (meq) ER (extended release) twice daily at 9 a.m. and 5 p.m. was not discontinued as ordered and continued to be administered twice daily from _____ through _____.

Review of the 2013 pharmacy computer generated MOR revealed the order for the _____ 40 mg daily was still documented on the MOR with a hand written notation discontinued on _____. Further review of the 2013 pharmacy computer generated MOR revealed the _____ 10 meq ER remained on the _____ MOR and continued to be documented as administered twice daily for the entire month.

Review of the 2013 pharmacy computer generated MOR revealed the _____ 10 meq ER continued to be documented as administered twice daily from _____ through _____ at which time a hand written notation documented the _____ was discontinued on _____. Review of the 2013 Physician Order Sheet revealed a hand written notation next to the _____

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... order stating 'per (physician's name) ... spoke to (nurse's name) ... 2:15 p.m. D/C (discontinued).

Review of the clinical record revealed another physician order dated ... to discontinue the ... 10 meq.

Review of the ... 2013 pharmacy computer generated MOR revealed the order for the ... continued to be documented on the MOR with a hand written notation it was discontinued on ...

During the exit conference on ... at approximately 4:00 P.M, the facility corporate Quality and Risk ... stated they must have gotten another order to discontinue the ... in ... however could not explain why the ... continued to be administered when it was ordered to be discontinued in ...

5) Review of Resident #4's record revealed a physician order dated ... for the one time dose of the ... 500 mg, take 4 capsules 1 hour prior to dental appointment.

Further review of the record revealed Resident #4 had a dental appointment on ...
Review of the ... 2014 MOR revealed the ... was administered on ... at 9 a.m.

Further review of Resident #4's record revealed a ... 2014 pharmacy computer generated MOR with the order for ... 1 hour prior to the dental appointment was carried over from the 2014 MOR to the ... 2014 MOR. Review of Resident #4's record revealed no further dental appointments since the ... appointment. Further review of the ... MOR revealed the ... was signed off as administered on ... and ...

During the exit conference on ... at approximately 4:00 P.M, the facility corporate Quality and Risk ... stated it looks like the nurses were just signing off the MOR without reading or thinking about what they were signing.

Class III

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0056-Medication - Labeling and Orders 58A-5.0185(7) FAC

Based on interview and record review, the facility failed to ensure medications were obtained in a timely manner for 1 of 4 sampled residents reviewed for medication administration, (Resident #3), As evidenced by medications not being commenced in a timely manner after receiving the physician orders.

The findings include:

Resident #3 was admitted to the facility on _____ with diagnoses to include _____ and back pain.

Review of the record revealed a physician order dated _____ for _____ (pain medication) 50 mg half tablet _____ (twice daily). Review of the _____ 2013 MOR revealed the _____ was not started to be administered until _____, 6 days after the physician's initial order.

Review of the record revealed a physician order dated _____ for a _____ 5% patch (used for pain) apply to skin 12 hours per day and an _____ patch (used for _____ 4.6 mg apply to skin daily. Review of the _____ MOR revealed the _____ patch and _____ patch were not started to be administered until _____, 3 days after the physician's initial order.

Review of the record revealed a physician order dated _____ for _____ (appetite stimulant) 400 mg daily by mouth. Review of the _____ 2014 MOR revealed the _____ was not started to be administered until _____, 9 days after the physician's initial order.

Review of the resident's Medication Observation Records (MOR) for _____ 2014 reveal she is taking Losarten (used for high _____ 50 mg daily. Review of the record revealed a physician order dated _____ to change the Losarten to 50 mg half tab (25 mg) by mouth daily. Review of the 2014 MOR documents the resident received the 50 mg of Losarten on _____ and _____ and not the reduced dose of 25 mg as was ordered on _____.

On _____ at approximately 4:00 P.M, the corporate Quality and Risk _____ stated a couple of days delay in obtaining medications is not unreasonable because there are sometimes issues with the pharmacies. However, she could not explain the extended delays in obtaining and starting the _____ and _____.

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Review of the record revealed no evidence of documentation the physician was notified of the delay in obtaining and administering the medications.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

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

Re: CCR #2013011050 & #2013011953

Dear Administrator:

This letter reports the findings of a State Licensure Complaint Survey 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,

J. Webb - Phoenix, Arizona
for Arlene Mayo - Davis
Field Office Manager

AMD/jw
Enclosure

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