STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964912	08/12/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Southpoint	6895 Belfort Oaks Place Jacksonville, FL 32216	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

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

Specific Tag Findings:

0000-Initial Comments
An unannounced licensure complaint survey, CCR # 2014007162, was conducted on 2014. Emeritus at Southpoint had deficiencies found at the time of the visit.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record review and staff interview, the facility failed to notify family of a significant change in condition for 1 of 3 sampled residents, Resident #2.

The findings include:

Resident #2 had a Healthcare Provider Communication Form revealing the resident had red spot rashes on her back and was complaining of itchiness. On , the doctor faxed over an order for Lotrisone Cream to be applied three times a day for 14 days. A dermatologist assistant wrote on a communication form on that the resident had (itchyness) with possible and ordered cream, apply to body and repeat in 14 days. On , the facility documented that the resident had small red spots on arm, chest, and back and complainded of itching. The doctor wrote an order for Lotrisone Lotion to be applied twice a day. On another physician order was seen for 5% apply neck to toe, consult with site for Decrease Lotrisone to daily.
There was documentation on from a consult that the resident was treated with on and Notes reflected that her improved greatly.

Review of the facility documentation did not reveal that the resident's power of attorney(daughter) was notified of the possible and treatment with on 4/1 and

The Resident Care Director on at 1:25 p.m. stated that they would have contacted the Resident's representative/ family member for being treated for She stated that the resident's daughter was the power of attorney for Resident #2. However, they did not have documentation that notification was given to her or any family member of Resident #2 of being treated for on 4/1 and

In an interview with Resident #2's daughter (power of attorney) on at 12:30 PM, she stated that she noticed a on Resident #2's body in 2014. Resident #2's daughter reported that she did not realize her mom had until she saw the bill from the pharmacy for the medication to treat She reported that she was not made aware by the facility that her mother received treatment for

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0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation, record review and staff interview, the facility failed to provide adequate control procedures consistent with community standards for 2 of 8 sampled residents, Residents #2 and #8 to prevent the

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spread of .

The findings include:

On . at 9:35 a.m., the Regional Care Director (RCD) stated that a few months ago they did have a group of residents in the Memory Care Unit who had . The RCD was asked for a list of residents who were treated for . She identified 9 residents. Resident #2 was not on the list. However, after resident record review, it was determined that Resident #2 was treated twice for , once in . and once in 2014. The facility was asked for their policy and procedure for . control. They produced a Standard/Universal Precautions and . Control . It did not specifically address . but it did have guidelines for gloves and handwashing. Hands should be washed after gloves are removed and hands should be washed before and after providing care to any resident. It is recommended that staff wash hands before leaving a resident's apartment.

Resident #2 had a . Healthcare Provider Communication Form revealing the resident had red spot rashes on her back and was complaining of itchiness. On , the doctor faxed over an order for Lotrisone Cream to be applied . three times a day for 14 days. A dermatologist assistant wrote on a communication form on . that the resident had chiness) with possible . and ordered cream, apply to body and repeat in 14 days. On , the facility documented that the resident still had small red spots on arm, chest, and back and complain of itching. The doctor wrote an order for Lotrisone Lotion to be applied twice a day. On . another physician order was seen for . 5% apply neck to toe, consult with on-site for . Decrease Lotrisone to daily. There was documentation on . from the consult that the resident was treated with . on . and . improved greatly.
There was more documentation on by Employee A , communicating with the physician that Resident #2 was continuously scratching her right thigh but no obvious signs of . noted. Daughter was . and would like for it be checked. On the resident was seen by the doctor who wrote a new order for . cream apply cream to right hip twice a day for 14 days for . This order was placed on the Resident's 2014 MOR and was given for three days. However, review of the Resident's . 2014 MOR revealed it was not continued and had not been given to the resident in . 2014.

On . at 1:35 p.m., the RCD stated that she did call the Department of Health about the . outbreak but did not have documentation of who she spoke to and when.

On . at 2:20 pm, the RCD and the Medication Technician, Employee D were asked to escort Resident #2 to her . observe her skin for any signs of . When her . was opened, another resident (Resident #8) was observed in her bed. Employee D escorted Resident#8 out of the . One of the pillows that Resident #8 was lying on did not have a pillow case on it and several areas of black dots were observed on it. The RCD stated that they can not stop residents from wandering in and out of . because they were not allowed to lock the doors.
Employee D had gloves on her hands. She inspected the resident's skin (Resident #2) with her gloved hands. The resident was asked if her right hip was itching. She stated yes. A few faint red dots were noted on her hip. After Employee D was finished, she removed her gloves. She did not wash her hands. She stated that she washed her hands in the main living there were no disposable towels in resident . to dry your hands.

The RCD on . at 2:25 p.m. confirmed that Resident #2 did not receive her treatment of . cream per physician orders for 14 days as ordered by the physician for her itchy skin. She also confirmed that

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there were no disposable paper towel in resident and was not aware that there were soap dispensers in there either.

Employee E, the Wellness Nurse on the shift was interviewed on at 3 pm. He stated that he was very involved with the outbreak in the Memory Care Unit and with Resident #2's treatment. He did acknowledge that residents do roam in and out of each other's some of them like to sleep in each other's bed and share clothing especially Resident #8. He stated that the process of treating all of the residents was overwhelming. It was difficult to get in touch with some of the doctors and insurance companies so he stated that Corporate suggested to just treat everyone in the Memory Care Unit for the There were only two residents with private who were not treated. Housekeeping was told to strip all of the beds of linen and wash resident clothing to prevent re-infe He stated that Resident #2 had her personal clothing routinely washed by her daughter. He could not say if the daughter was told of the outbreak and that all of the resident's clothing should be washed. Employee E also stated that he did not wash his hands in the resident either after care of a resident, but only rinsed them. He reported that the facility did not have soap in resident until recently and still did not have anything to dry hands with. So he too went to the main dining wash his hands. He stated that was not the best practice but that was the only thing they could do.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Emeritus At Southpoint
6895 Belfort Oaks Place
Jacksonville, FL 32216

RE: CCR #2014007162

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on , 2014 by a representative of 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 **10/02/2014** 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 surveyor. Should you have any questions please call this office at .

Sincerely,

Jana Meyering, CIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

LW/JM/sm
Enclosure

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