STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11912046	08/19/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Livewell At Coral Plaza	5850 Margate Blvd. Margate, FL 33063	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced licensure complaint survey, CCR# 2014006164, #2014005964 and # 2014005985, was conducted on [redacted] through [redacted] at Livewell at Coral Plaza. The facility had 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 ensure resident records accurately reflected their conditions for 4 out of 4 sampled residents (Resident #1, #2, #3, and #4). As evidenced by the facility failing to appropriately document observation and assessment of wounds for Residents #1 and #2; and failure to document assessment, observations and inform the physician of hange in condition for 3 out of 4 sampled residents (Resident #1, #3 and #4)

The findings include:

1) Resident #1 was admitted to the facility with medical diagnosis including [redacted] The resident has unsteady gait and utilizes a rolling walker. She is independent for all ADL except bathing.

Record review of an incident report dated [redacted] at 5 PM reveals the Director of Nursing (DON) was called to the resident's [redacted] The report shows that the resident stated "she had slip, not [redacted] a few days ago". The nurse noted a large [redacted] to the resident's right [redacted], with range of motion, the resident complained of slight discomfort on her right [redacted] The report documents, "will monitor resident". There were no witnesses noted on the report. The form was signed as reviewed by DON. The documented interventions made at the time included: resident advised to call for any assistance and call bell cord in [redacted] The form documents no notification of the injury to the physician or family. Review of the progress notes regarding monitoring of the [redacted] revealed no documentation of the injury or monitoring by the facility nursing staff.

On [redacted] at approximately 2:00 PM during an interview with the resident, she stated that she recalled that she had attempted to move around her [redacted] the walker and [redacted], [redacted] her [redacted] She stated she [redacted] backwards landing on her back. She stated that she had a history of [redacted] and unsteady balance, now requiring use of the rolling walker at all times.

Record review of an incident report dated on [redacted], the current DON completed the incident report. The resident was attempting to enter the facility bus and tripped, injuring her left lower leg. The

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form documents the DON cleansed the , applied a dry dressing and applied an ice pack to the area. The report notes interventions to include: wear appropriate shoes, ask for assistance getting on the bus, and refer to home health agency if necessary. Review of the report reveals no notification of the injury to the physician or family.

Review of the facility Progress Note dated reveals the resident was seen by the physician. The resident complained of a scraped left leg which was and that she was not walking well. Daily care by Home Health Nurse, and physical was ordered by the physician. Review of the facility Progress Notes reveals no observation or documentation of the prior to the physician visit noted.

During an interview conducted with the DON on at 12:00 PM, she states that the facility expectation is all staff will complete the incident report accurately and thoroughly. Furthermore, the staff should inform the physician and family of any injury. She acknowledged the staff should be documenting their observations, interventions made as well as physician notification of concerns, change in resident condition or injury.

2) Resident #2 was admitted to the facility with medical diagnoses of , history of , and gait imbalance. The resident requires supervision due to with her ADL care and assistance with medications.

Review of facility Progress Notes reveals on , the resident was seen by her physician with no further notes until On , the note reveals the resident was seen by her physician for a boil on her chest. The physician writes orders for and care to be provided by the Home Health Agency. Further review of the Progress Notes reveals no observations or assessment of the boil completed by the facility nursing staff. Review of initial Home Health Nurse Notes dated reveals a on the right chest wall, measuring 2 x 1.75 x raised 1.5 cm boil, intact with small amount pink drainage noted, and surrounding tissue reddened and hard. There was no further documentation regarding aforementioned condition.

During an interview conducted with the DON on at 12:00 PM, she reviewed the record and acknowledged the nursing staff should be documenting their observations, interventions and physician notification of concerns, change in resident condition or injury. The record had no documentation of observation or assessment of the boil by the facility nursing staff.

3) Resident #3 was admitted on with medical diagnosis of memory and . The resident ambulates with the use of a rolling walker and is at risk for . She is noted to be independent for most ADL care except bathing and transfers.

Review of the incident report dated , at 5:30AM, the aide found the resident on the floor in

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resident's . The resident stated she had slipped, when getting up to go to the , no injury was noted. The DON reviewed and signed the report on , no notification call was made to the physician or family. Nursing interventions noted was resident to wear socks with non slip bottoms or slippers.

Review of the incident report dated at 9:20 PM, the resident was found on the on lying on her right side, by the Medication Technician. The resident stated she slipped off the toilet . The resident was assessed to have no or and no complaint of pain was expressed. Further review revealed that there was no review by the DON and no call to the physician or family . Nursing interventions included inform resident to use call light when needing help; no further investigation was conducted by the nursing staff.

During an interview conducted with the DON on at 12:00 PM, she reviewed the record and acknowledged the nursing staff should be documenting their observations, interventions and physician notification of concerns, change in resident condition or . The resident is noted to have memory , ambulates with walker, and is at risk for .

4) Resident #4 was admitted with medical diagnosis of unsteady gait, tremors, and previous right hip repair. The resident is alert, but forgetful and requires total assistance with all ADL care. She is at risk for and requires precautions.

Review of the record reveals the resident is hospitalized on for . The resident is readmitted to the facility on . On the physician visits and notes the resident is alert but having hallucinations. Lab work is ordered. No nursing progress notes were noted in the residents record regarding observations for the resident.

Review of a telephone physician order dated reveals the resident has complaint of pain and of the left foot. The physician orders 500 mg twice a day and an evaluation by the Home Health Nurse of the affected leg. There was no facility progress notes documenting the observations of the resident condition could be located.

Review of the Home Health Agency Nurses note dated revealed the observation of left foot. The nurse identified that the extremities were and redness of the right ankle and heel. The resident complained of pain level at score . The skin on both legs was intact.

Review of the incident report dated at 8:05 AM, reveals the resident is found on the floor in her , by the aide. The resident was asking for help to get up and was complaining of pain in her right hip. The report documents the aide reported the incident to the Medication Technician on duty. was called and the resident was transferred to the hospital for evaluation. The report is blank for notification of the physician or family. Further review of the facility Progress Notes reveals no

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documentation of the ... or interventions taken by facility nursing staff. There is no documentation of the condition of the resident upon arrival to the hospital.

During an interview conducted with the DON on ... at 12:00 PM, she reviewed the record and acknowledged the nursing staff should be documenting their observations, interventions and physician notification of concerns, change in resident condition or .... She stated the resident was currently at a rehabilitation center after injury from the ....

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Livewell At Coral Plaza
5850 Margate Blvd.
Margate, FL 33063

RE: CCR #2014005964, CCR #2014005985 & CCR #2014006164

Dear Administrator:

This letter reports the findings of a complaint surveys that were conducted on , 2014 and , 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 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
Enclosure

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