STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942934	**04/21/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
GRAND COURT ALF	**295 SW 4TH AVENUE POMPANO BEACH, FL 33060**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced Biennial Standard Relicensure with Extended Congregate Care and Limited Mental Health survey was conducted on [redacted] and [redacted] at Grand Court ALF. The facility had deficiencies found at the time of the visit.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview, the assisted living facility (ALF) failed to ensure a resident's Health Assessment form (AHCA form 1823) and Hospice Integrated Plan of Care was accurate and reflective of a resident's current care needs and services, for 2 out of 2 residents (Resident # 6); and failed to obtain a new medical examination (AHCA Form 1823) when a resident experienced a significant change in condition (Resident #45) .

The findings include:

1. A review of Resident # 6's file revealed an admission date of [redacted] Resident # 6's last medical exam is dated for [redacted] with the following diagnosis:
[redacted], Left hip [redacted] and Syncopal Episodes.
Record review of Resident # 6's file revealed she is currently receiving Hospice Services from Vitas since [redacted] with a hospice diagnosis of [redacted]. However, Resident # 6's Hospice Integrated Plan of Care dated for [redacted] has not been updated to reflect Resident # 6's change in diet and has no individualized specification of the services being provided by hospice and those being provided by the facility. (Copy obtained).

Further review of Resident # 6's AHCA form 1823 indicates special diet instructions for a low fat and low cholesterol diet. On [redacted] at 12:30 PM during lunch time, Resident # 6 was observed being served and eating a pureed lunch meal. A record review of the facility's resident therapeutic diet list revealed Resident # 6 is on a pureed diet. Further record review of Resident # 6's file found no physician order for a pureed diet and no new AHCA 1823 indicating a significant change in Resident # 6's diet (Copy obtained).

In an interview with the Direct Care Night Supervisor/ Med tech on [redacted] at 10:35 AM, she stated Resident # 6 could not tolerate regular foods and she could only tolerate pureed food. In an interview with the Administrator on [redacted] at 2 PM, she was informed of Resident # 6's significant change in diet and a lack of an individualized hospice Integrated Plan of Care for Resident # 6. At 2:35 PM, the Administrator acknowledged the findings and stated no further documentation was available for review.

2. Review of Resident #45's medical examination (AHCA Form 1823) documented she required assistance with self-administration of medications. On [redacted] at 10:20 AM
and [redacted] at 8:25 AM (with the Director of Nursing (DON) present), she was observed to not be able to participate in the act of self-administration. Reference Citation A0052 herein. On [redacted] at 8:25 AM, the DON stated she

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needed a new 1823.

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185(3) FAC

Based on observations, interviews and record review, the facility failed to ensure unlicensed staff who assisted residents with self-administration of medications maintained required standards of practice for 4 of 9 sampled Residents (#40, 45, 59 and 87) by allowing them to administer medications to a resident, crushing medications without written Health Care Provider (HCP) orders, disposing of wasted medications in the trash, and initialing residents' medication observation records (MOR's) before assisting the resident to self-administer their medications.

The findings include:

Medication systems review conducted with Employee A, a Medication Technician (MT) and Certified Nurse Aide (unlicensed staff) revealed the following concerns:

1. On [redacted] at 10:20 AM she was observed feeding medications in yogurt with a spoon to Resident #45. The MT also held a cup of water to the resident's mouth to drink. The resident did not participate in any manner.

2. During the above observation, Resident #45 spit an [redacted] 81 milligrams (MG) and a [redacted] back in to her cup of water and refused to take the Pantaprozal, [redacted] and [redacted] that had not yet been taken. The MT returned to her medication cart with the medications, fished the [redacted] and [redacted] out of the water and tossed them in the trash bin attached to the medication cart. She did not take any steps to properly dispose of the medications, such as presenting them to a designated person for proper disposal and documentation.

3. After Resident #45 spit out two medications and refused to take the other three, the MT crushed the five pills (including an extended release [redacted] stating she would not take them unless she crushed them and mixed them with yogurt. She did so and successfully fed them to the resident. Additionally, it was observed the pill crusher used was excessively soiled throughout and scores of rubber [redacted] were stored on the handle near the crushing area. Review of Resident #45's record revealed no written HCP order calling for specific medications to be crushed. There was no informational note in the resident's record to crush specific medications.
This was brought to the Director of Nursing's (DON) attention on [redacted] at 1:09 PM, she acknowledged there were no written HCP provider orders that called for these residents' medications to be crushed and stated the condition of the pill crusher was not acceptable.

4. Observations of Employee A initialing the residents' MOR's before actually assisting them with self-administration of medications were made as follows:
a. On [redacted] at 10:20 AM she [redacted] initialed doses for [redacted] and [redacted] for Resident #45.

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b. On ... at 10:47 AM she ... initialed doses for ... and ... for Resident #59.
c. On ... at 8:56 AM she ... initialed doses for ... and Flaxseed Oil for Resident #87.
d On ... at 10:51 AM she ... initialed doses for ... C, ... and ... for Resident #40.

These concerns were brought to the Director of Nursing's (DON) on ... at 1:09 PM. In an interview conducted ... at 2:05 PM, these concerns were discussed with and acknowledged by the Administrator with the DON present.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observations, interviews and record review, the facility failed to ensure licensed nurse staff followed written Health Care Provider (HCP) orders, for 3 of 9 sampled Residents (#4, #8 and #9) by crushing medications without a written HCP order to do so.

The findings include:

Medication systems review was conducted ... with Employee E, a Licensed Practical Nurse. Observations were made of her crushing and administering resident medications as follows:
1. Resident #4 received crushed ... at 12:46 PM
2. Resident #8 received crushed ... at 12:50 PM
3. Resident #9 received crushed Atarax and ... at 12:56 PM
In an interview conducted at 1:02 PM, Employee E stated she crushed the medications based on her knowledge of what medications can be crushed, and it was not based on a HCP order. Additionally, it was observed the pill crusher used was excessively soiled throughout and a rubber ... was stored on the handle near the crushing area.

Review of Resident #4, #8 and #9's records revealed no written HCP order calling for these residents' medications to be crushed. There was no informational note in the three residents' records to crush medications.

These concerns were brought to the DON's attention at 2:09 PM, she acknowledged there were no written HCP provider orders that called for these residents' medications to be crushed and stated the condition of the pill crusher was not acceptable.

In an interview conducted ... at 2:05 PM, these concerns were discussed with and acknowledged by the Administrator with the DON present.

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Class III

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

Based on observations, interviews and record review, the facility failed to maintain accurate medication observation records (MOR's) and medication administration records (MAR's) for 3 of 9 sampled Residents (#4, #9 and #40) by incorrectly recording as-needed (PRN) medication effectiveness, data entry errors on a inventory sheet, and duplicating medication orders on a resident's MOR.

The findings included:

Medication systems review conducted throughout the two-day survey revealed the following concerns:

1. Employee A, a Medication Technician (MT) and Certified Nurse Aide was observed to assist Resident #40 with an as-needed (PRN) pain medication, on at 10:51 AM. She then initialed the front of the MOR and documented the reverse side to indicate the entry was complete. This was brought to the Director of Nursing's (DON) attention on at 10:58 AM, she stated the MT should have waited an hour and documented if the pain medication was effective or not later.
2. Employee E, a Licensed Practical Nurse (LPN) was observed to administer a PRN pain medication to Resident #4 on at 12:46 PM. She then immediately initialed the front of the MAR and documented the reverse side to indicate the pain medication was effective. In an interview at the time of observation, she stated she should have come back later to document that the pain medication was effective. This was discussed with and acknowledged by the Director of Nursing's (DON) in an interview conducted on at 2:09 PM.

3. A review of Resident #9's inventory sheet for conducted at 1:55 PM revealed the written number of pills on hand was documented as 18. A count of the actual number of pills in the medication container revealed a quantity of 20 pills on hand, 2 more than staff had documented. The DON researched the discrepancy and on at 2:00 PM, she stated staff had written two dates with no pills actually used and the written quantity should be 20.

4. Review of Resident #40's 2015 MOR revealed duplicate entries for Staff members were documenting on both entries. This was brought to the DON's attention on at 10:58 AM, the DON stated they were duplicate entries and wrote "duplicate order" on the second entry.

The above concerns were discussed with and acknowledged by the Administrator, with the DON present, on at 2:05 PM

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0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observations and interviews, the facility failed to ensure licensed and unlicensed staff properly stored resident medications for 2 of 2 sampled medication carts (the Nurse Cart and the Medication Technician Cart) evidenced by loose pills and expired medications observed in both medication carts.

The findings include:

Medication cart inspections were conducted on [redacted] with the Director of Nursing (DON) present, and revealed the following concerns:

1. At 1:55 PM with Employee E, a Licensed Practical Nurse present, the Nurse medication cart was observed to contain six pills laying loose within the medication storage area. Five were identified as [redacted] 500 milligrams; the sixth was white, round and had no markings and could not be identified (photographic evidence obtained).

2. At 1:15 PM with Employee A, a Medication Technician and Certified Nurse Aide, Medication Technician medication cart was observed to contain one pill laying loose within the medication storage area. It was white, round and scored but had no markings and could not be identified (photographic evidence obtained).

3. At 1:15 PM, the Medication Technician medication cart was observed to contained the following expired medications (photographic evidence obtained):
a. Resident #83 had Fish Oil capsules that expired [redacted]
b. Resident #45 had [redacted] tablets that expired [redacted]
c. Resident #55 had [redacted] eye drops that expired [redacted]

These concerns were discussed with and acknowledged by the DON at the time of observation, and by the Administrator on [redacted] at 2:05 PM.

Class III

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

Based on observations, interviews and record review, the facility failed to ensure timely refills for medications, and failed to follow written Health Care Provider (HCP) orders for 1 of 9 sampled Residents (#45).

The findings include:

Medication systems review conducted on [redacted] revealed the following concerns:

1. At 8:36 AM, Resident #45 was observed to receive her morning medications. Review of her medication

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observation record (MOR) revealed orders for Tears 1.4% one drop in both eyes three times daily, and lubricant eye drops 0.4%/0.3% one drop in both eyes every four hours. Observation of her medication on hand revealed neither of these two medications were available for the resident's use. In an interview conducted at that time, Employee A, a Medication Technician (MT) confirmed the two medications had run out. In an interview with Employee F conducted at 10:15 AM, she stated the medications were ordered the night before and presented a pharmacy reorder form. The form documented it was faxed to the pharmacy at 11:40 PM. She confirmed there was no further documentation related to this concern. As a result, these two medications were not available for the resident's scheduled morning doses. Facility staff failed to make every reasonable effort to ensure these medications were refilled in a timely manner. This was discussed with the Director of Nursing (DON) at 2:16 PM.

2. Review of Resident #45's records revealed a written HCP order dated that called for lubricant eye drops 0.4%/0.3% one drop in both eyes every four hours. Her 2015 MOR documented the same order. The times the resident was to actually receive the medications were documented next to the order as 8:00 AM, 12:00 PM (4 hours later), 5:00 PM (5 hours later) and 8:00 PM (3 hours later). The resident would have to wait 12 more hours to receive the next dose. Facility staff failed to ensure this resident's medication doses were not changed without a HCP's written order. This was brought to the DON's attention at 2:16 PM, she acknowledged the MOR did not follow the HCP order as written.

The above concerns were discussed with and acknowledged by the Administrator on at 2:05 PM with the DON present.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on interview and record review of the staff personnel records, it was determined the facility failed to ensure that 1 out of 4 staff members (Staff A), submitted an annual statement from a physician, that the person is free from and communicable

The findings include:

Record review of the facility personnel records revealed Staff A's hire date was Further review revealed Staff A's file lacked documentation from a physician indicating the employee is free from and communicable

In an interview with Administrator on at approximately 12:30 PM, she acknowledged the findings.
Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

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Based on observations, interviews and record review, the facility failed to properly prepare and serve therapeutic diets as ordered by residents ' Health Care Providers (HCP ' s) for 5 of 6 sample Residents (# ' s 8, 13, 25, 41 and 87); and failed to follow their menu related to portions served to the 25 residents living in the secured unit.

The findings include:

1. On ... at 12:17 PM, Residents #6, 13 and 25 were observed eating pureed chicken quesadillas in the secured unit dining ... They were not served soup like the other residents were. They were served butterscotch pudding instead of chocolate chip cookies like the other resident were. In an interview conducted ... at 10:35 AM with the secured unit ' s Dining (Employee G), a Home Health Aide, stated these residents could not tolerate regular foods and could only tolerate pureed foods. She also stated that pureed soup was not good for them so they were not served soup.

Review of facility records and resident records conducted ... revealed the following:

a. Resident #6 has pertinent diagnoses of and ... Her medical examination (AHCA Form 1823) dated ... documented she requires a low fat, low ... diet.

b. Resident #13 has pertinent diagnoses of hypopotassemia, , and protein caloric ... Her medical examination (AHCA Form 1823) dated ... documented she requires a mechanical soft diet.

c. Resident #25 has pertinent diagnoses of ... D deficiency, , and ... Her medical examination (AHCA Form 1823) dated ... documented she requires a no added salt, no concentrated sweets diet.

Review of the facility ' s therapeutic diet list documented these three residents were to receive a pureed diet. Further record review revealed no documentation showing a Health Care Provider (HCP) prescribed a puree diet for any of these residents, or was consulted related to these significant changes in resident diets. This was brought to the Director of Nursing ' s (DON) attention on ... at 2:00 PM. She looked in to it and stated Employee G had determined these three residents required pureed diets and instructed the kitchen to prepare pureed foods for them. She stated this was not acceptable practice.

In an interview conducted ... at 1:50 PM, the facility ' s Food Service Designee (FSD) was asked and stated whoever asks for pureed food will get it. He had no explanation why kitchen staff did not puree soup or cookies for the residents who received pureed foods.

2. Review of resident and facility records documented the following:
a. Resident #47 ' s medical examination (AHCA Form 1823) dated ... documented he required a ... diet and

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a low salt, fat and diet.
b. Resident #87 ' s medical examination (AHCA Form 1823) dated documented she required a diet and a and no concentrated sweets diet.
In an interview conducted at 1:15 PM, the facility ' s FSD was asked and stated he was aware there are residents who receive services but had no special menus to follow for them and does nothing special related to the meals they are served such as substituting high foods with foods not high in

3. Observations of meal service provided to the 25 residents living in the facility ' s secured unit were conducted during the survey. The following concerns were noted:
a. On at 12:17 PM, the residents were served one chocolate chip cookie each with their lunch. Review of the daily menu revealed it called for two chocolate chip cookies for each resident. Two residents were observed asking for another cookie and were told by staff that they didn ' t have any more.
b. On at 8:38 AM, the residents were served one pancake each with their breakfast. Review of the daily menu revealed it called for two pancakes for each resident.
In an interview conducted at 9:07 AM, the FSD was asked why and stated he would look in to it. At 10:25 AM, he stated his kitchen staff told him them didn ' t know how many to send.

In an interview conducted on at 2:35 PM with the Director of Nursing present, the Administrator acknowledged the above concerns.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observations and interviews, the facility failed to maintain bathtubs and appurtenances in good working order.

The findings include:

Observations of resident and the facility's main lobby conducted revealed the following concerns:

1. In resident at 10:12 AM, the bathtub was cracked on the inner side of the walk-in opening.

2. In resident at 11:03 AM, the inside door knob cover was loose and rattling on the door handle, exposing a rough edge of the covering; and in his , the:
a. over-toilet commode had paint cracked off in a 2"x1" area with rust-colored metal exposed on front center of the seat
b. inside had multiple deep scratches spanning width of door
c. paint on the back of the sink was cracked in multiple areas
d. sink countertop was soiled

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e. mirror had oxidized on left and right bottom
f. trash can was stored on the top of the back of toilet and a staff member was observed to place a liner in the can and leave it there

3. In resident [redacted] at 1:47 PM, the [redacted] had multiple deep scratches and the veneer was cracked off in an 18"x1" area, and the electrical outlet cover located to the left of the beds was cracked.

4. In the [redacted] resident [redacted] at 3:01 PM, the:
a. bathtub was cracked on the inner side of the walk-in opening
b. door jamb had unsightly black marks in a 2' high area
c. bath mat had green and black spotty matter throughout

5. In the main lobby at 10:01 AM, carpet was soiled, especially in the high-traffic areas.

These concerns were discussed with and acknowledged by the Administrator and Director of Nursing on [redacted] at 2:10 PM.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Administrator
Grand Court ALF
295 SW 4th Avenue
Pompano Beach, FL 33060

RE: Relicensure Survey

Dear Administrator:

This letter reports the findings of a state Relicensure survey that was conducted on 2015 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

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida