STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965413	12/22/2017
NAME OF PROVIDER OR SUPPLIER **COCONUT CREEK**	STREET ADDRESS, CITY, STATE, ZIP CODE **4175 WEST SAMPLE ROAD COCONUT CREEK, FL 33073**	

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

0000 - Initial Comments

A Limited Nursing Service (LNS) monitoring visit was conducted on at Coconut Creek, an Assisted Living facility, License #9784. The facility had deficiencies at the time of the visit.

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

Based on observation, interview and record review, the Assisted Living Faciltiy (ALF) failed to ensure the safe storage and administration of medications for 2 of 7 residents reviewed receiving Limited Nursing Services (LNS), Resident #3 and Resident #7. As evidenced by open storage of breathing treatment medication for Resident #3; and a private duty aide, non ALF staff member administering inhalation breathing treatments to Resident #7 that were stored in open view.

The findings included:
1) Review of the LNS Log revealed Resident #3 was ordered to receive LNS on to assess and monitor the use of continuous . Review of the LNS progress note documentation revealed the nurses were documenting their assessment of the resident twice daily in addition to monthly assessments conducted by a Registered Nurse.

On at 10:40 AM an observation was conducted, accompanied by the Administrator, of Resident #3's he shares with his spouse, who the Administrator stated was lower functioning. Observed sitting on the Resident #3's bedside table were 3 packages of inhalation medications in open view. The Administrator acknowledged these medications should not be stored in the open and stated he will have the nurse remove them. On at 11:35 AM the Administrator stated he has instructed the nurse to remove the medication from the bedside and ensure the medications are locked up in the medication cart.

2) Review of the LNS Log revealed Resident #7 was ordered to receive LNS on to assess and monitor the use of continuous . Review of the LNS progress note documentation revealed the nurses were documenting their assessment of the resident twice daily in addition to monthly assessments conducted by a Registered Nurse.

On at 10:30 AM, Resident #7 was observed sleeping in his a private duty aide in attendance. Resident #7 was observed using continuous . Further observation revealed 2 packages of inhalation breathing treatments, one orange package and one purple package, on the resident's night stand sitting on top of a piece of paper with directions for use: the orange medication package is due at 6 AM and 6 PM and the purple medication package is due at 6 AM, 12 PM, 6 PM and 12 AM. An interview was conducted with the private duty aide at this time inquiring about these

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instructions to which she replied, picking up the orange package, this one is due at these times, and picking up the purple package, this one is due at these times. An inquiry was made if she is administering Resident #7's inhalation breathing treatments to which she stated the nurses gave her these instructions which she follows. She then she proceeded to demonstrate how she instills and sets up the medication in the aerosol chamber stating she then turns the machine on and puts the mask on the resident's face.

On at 10:45 AM an interview was conducted with the Administrator apprising him Resident #7's private duty aide is administering the inhalation breathing medication that is stored at the bedside. The Administrator stated he was unaware the nurses were not administering the inhalation medications, stating they assist with administering all the other medications.

Review of the 2017 Medication Observation Record revealed the facility nurses were signing off the inhalation breathing treatments as being administered by them and not the private duty aide.

On at 11:35 AM, the Administrator stated he has taken care of this situation and the private duty aide will no longer be administering the medications, further stating they will put the administration of the inhalation medication as part of the LNS related to the use of the .

Class III

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

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure the safe storage of canisters was maintained for 2 of 4 residents reviewed for Limited Nursing Services (LNS) for the administration and assessment of the use of for Resident #3 and Resident #5. As evidenced by canisters observed in the resident's were not stored in a secure manner for Resident #3 and Resident #5.

The findings included:
1) Review of Resident #3's record revealed he was placed on LNS on for the use of continuous via nasal cannula. Review of the LNS Log revealed minimum daily nursing progress notes documenting changing the resident from a portable tank to an concentrator and vice versa. Additionally, monthly assessments are being completed by a Registered Nurse (RN).

On at 10:35 AM, accompanied by the Administrator, Resident #3's living quarters was observed to reveal 4 large canisters and 3 small canisters freestanding on the floor. The Administrator acknowledged the canisters must be properly secured to prevent the

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canisters being potential projectiles if accidentally knocked over. The Administrator further stated, the hospice agency looks after the and he will call them to come and secure the tanks.

2) Review of Resident #5's record revealed she was placed on LNS on for the use of continuous via nasal cannula. Review of the LNS Log revealed nursing progress notes twice daily in addition to monthly assessments completed by a RN.

On at 10:40 AM, Resident #5's living quarters was observed to reveal 5 large canisters freestanding on the floor. An interview was conducted with Resident #5 at this time who confirmed she uses the on a continuous basis and cannot be without it.

On at approximately 10:50 AM, the Administrator was apprised of the unsecured tanks in Resident #5's . The Administrator stated he will address this right away.

On at 11:35 AM, the Administrator stated he has contacted the hospice agency to come and secure the tanks, and they will check all the tanks in the building to ensure they are stored safely.

Class III

N276 - LNS - Nursing Services - 58A-5.031(1) FAC

Based on observation, interview and record review the Assisted Living Facility (ALF) failed to ensure Limited Nursing Services (LNS) were rendered for 1 of 2 residents reviewed for LNS for the application of hose, Resident #6. As evidenced by observation of Resident #6 without hose applied.

The findings included:
Review of the LNS Log for Resident #6 revealed a physician order dated for hose application to legs to be applied in the morning and removed at bedtime for a diagnosis of .

Review of a physician Progress Note dated documents the resident with ' trace lower extremities.'

Review of the Nursing Progress Notes revealed nursing documentation twice daily for the application and removal of the hose. The nursing documentation on at 8:50 AM stated ' hose applied as ordered.'

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On at 10:55 AM, Resident #6 was observed sitting in a wheelchair wearing long pants and anklet socks and skin showing between the socks and hem of her pants. hose were not observed to be in place.

On at 11:05 AM review of the residents' Medication Record revealed the nurse had signed off she applied the hose at 8:00 AM this morning.

On at 11:08 AM, the resident not having hose in place and the nurse signing off she had applied them, was brought to the attention of the Administrator. The Administrator observed for himself and confirmed the resident did not have hose on.

On at 11:10 AM the Administrator called the Licensed Practical Nurse (LPN) to the unit and inquired why Resident #6 did not have her hose on. The LPN stated she removed the hose after the hospice nurse was in this morning, further stating the resident was restless and did not want them on and refuses to have the hose applied a number of times. The LPN confirmed she had not documented the refusal. Review of the 2017 Medication Record revealed for the month of , nursing signed off the application of the hose at 8:00 AM and removal at 8:00 PM with no evidence of documentation of resident refusals. The LPN could not speak to the consistent documentation of the application and removal of the hose in the Medication Record. The Administrator stated to the LPN at this time, the hose are for the leg and it is a physician order that needs to be followed. The LPN verbalized her understanding and stated she will attempt to reapply the hose on Resident #6.

Class III