STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965218	**06/15/2018**
NAME OF PROVIDER OR SUPPLIER **LAKEVIEW RETIREMENT RESIDENCE, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2304 NW 52ND COURT** **FORT LAUDERDALE, FL 33309**	

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 [redacted] at Lakeview Retirement Residences Inc., an Assisted Living facility, License #9618. The facility had deficiencies at the time of the visit.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, interview and record review the Assisted Living Facility (ALF) failed to to ensure resident records accurately reflected their condition for 3 of 7 resident records reviewed, as evidenced by failing to document the status of a [redacted] for Resident #1; and failed to document the condition of Resident #6 and Resident #7 requiring a visit to the hospital emergency [redacted] the status of the resident upon return to the facility.

The findings included:

Review of the form the ALF utilizes to document resident Progress Notes states in a box at the bottom right of the form 'Instructions: Any changes in the resident's condition and/or status must be documented immediately. Please make sure that a note indicating what action was taken to address the problem is clearly shown after each entry and signed.'

1) On [redacted] at 9:50 AM, a facility tour was conducted accompanied by the ALF Administrator. Upon entering the outside courtyard, Resident #1 was observed to have a gauze dressing on her left [redacted] with a date written on the gauze of [redacted]. An inquiry was made to the ALF Administrator what kind of [redacted] was under the gauze dressing to which she stated it was a [redacted]. A further inquiry was made how the resident sustained the [redacted] to which she stated she was not sure.

Review of the resident Progress Notes revealed no documentation of the status of the [redacted] or how it was sustained. Further, there was no physician order for [redacted] care.

On [redacted] at 11:40 AM an interview was conducted with the ALF dedicated Licensed Practical Nurse (LPN) and an inquiry was made about Resident #1's [redacted] to which she stated she just found out about it this morning when she came in and she does not know how the [redacted] happened. She stated it was the hospice nurse who saw it, contacted the physician and received the order for [redacted] care. A request was made to see the physician order for [redacted] care, however the LPN stated the hospice nurse took the order with her to be signed by the physician. During the interview with the LPN, the ALF Administrator joined in stating one of the aides reported the [redacted] to her yesterday, further stating

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965218	**06/15/2018**
NAME OF PROVIDER OR SUPPLIER **LAKEVIEW RETIREMENT RESIDENCE, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2304 NW 52ND COURT** **FORT LAUDERDALE, FL 33309**	

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

hospice is looking after it. An inquiry was made to the ALF Administrator how the resident sustained the and what did it look like, to which she could not comment. The ALF Administrator was apprised there is no documentation in Resident #1's record related to the to which she concurred there should be some documentation in the record about the and how it occured.

2) Review of the Progress Notes for Resident #6 revealed an entry dated , no time, 'Found patient on floor. Sent to (name of hospital) to be evaluated.' There was no documentation why the resident was sent to the hospital to be evaluated, no description of the circumstances, no documentation if an injury was sustained and no documentation if the physician or family had been notified. The next entry is dated , no time, 'Returned to facility from (name of hospital). Continue previous medications.' There was no evidence of documentation about the status of the resident upon his return to the facility. Review of an Incident Report dated , no time, documented 'Resident found on floor sent to (name of hospital). There was no further description or circumstances of the incident, no documentation if an injury was sustained and no documentation if the physician or family had been notified.

On at 12:15 PM an interview was conducted with the LPN inquiring about the status of Resident #6 requiring him to go to the hospital to which she stated Resident #6 and hit his head and was sent to the hospital. The LPN concurred they should have documented more information.

3) Review of the Progress Notes for Resident #7 revealed an entry dated , no time, '911 called sent to (name of hospital) to be evaluated.' There was no documentation why the resident was sent to the hospital to be evaluated, no description of the circumstances, no documentation if an injury was sustained and no documentation if the physician or family had been notified. The next entry is dated , no time, 'Resident returned to facility.' There is no documentation of why the resident was out of the facility for 4 months.

On at 12:45 PM an interview was conducted with the LPN inquiring about the status of Resident #7 requiring her to go to the hospital to which she stated she does not recall the exact reason the resident went out however the resident was readmitted from a rehabilitation center. The LPN concurred they should have documented more information.

Review of the ALF Communication Policy Regarding Resident's Change of Status states in part, 'It is the policy to inform the resident, family member, guardian and healthcare providers in the event of - An incident/accident occurring; Residents needing to go to the hospital; An emergency or change in resident's physical and/or mental health status.....Contact resident's guardian and physician if there are any changes in the physical and/or mental health status of the resident.....Incident/accident report

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965218	**06/15/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW RETIREMENT RESIDENCE, INC	**2304 NW 52ND COURT FORT LAUDERDALE, FL 33309**

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

should be completed and placed in the resident's file as soon as possible after resident is secured and necessary contacts have been made.'

Class III

0031 - Resident Care - Third Party Services - 58A-5.0182(7) FAC

Based on observation, interview and record review the Assisted Living Facility (ALF) failed to ensure communication was maintained between a Hospice agency and the ALF for 1 of 4 residents reviewed receiving hospice services, Resident #1, as evidenced by the ALF failing to communicate with the Hospice agency for Resident #1 related to the status of a .

The findings included:
On at 9:50 AM a facility tour was conducted accompanied by the ALF Administrator. Upon entering the outside courtyard, Resident #1 was observed to have a gauze dressing on her left with a date written on the gauze of . An inquiry was made to the ALF Administrator what kind of was under the gauze dressing to which she stated it was a . A further inquiry was made how the resident sustained the to which she stated she was not sure. An inquiry was made who changed the dressing yesterday to which she stated it would have been the hospice nurse.

Review of the resident Progress Notes revealed no documentation of the status of the or how it was sustained. Further there was no physician order for care. Review of the Hospice communication notes revealed no documentation regarding the left .

On at 11:40 AM an interview was conducted with the ALF dedicated Licensed Practical Nurse (LPN) and an inquiry was made about Resident #1's to which she stated she just found out about it this morning when she came in and she does not know how the happened. She stated it was the hospice nurse who saw it, contacted the physician and received the order for care. A request was made to see the physician order for care, however the LPN stated the hospice nurse took the order with her to be signed by the physician. During the interview with the LPN, the ALF Administrator joined in stating one of the aides reported the to her yesterday, further stating hospice is looking after it. An inquiry was made to the ALF Administrator how the resident sustained the and what did it look like, to which she could not comment. The ALF Administrator was apprised there is no documentation in Resident #1's record related to the to which she concurred there should be some documentation in the record about the .

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965218	06/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW RETIREMENT RESIDENCE, INC	**2304 NW 52ND COURT FORT LAUDERDALE, FL 33309**

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

Review of the facility Accident/Injury Policy states in part, 'If a resident is injured, the attending physician and family or responsible party must be notified. The incident should be recorded on the nurse's notes with date, time, brief description of incidents, and any injuries incurred.'

Class III

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

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure the safe storage of medications as evidenced by observation of medications in plain sight in Resident #1 and Resident #5's living quarters.

The findings included:
On during the facility tour at 10:00 AM accompanied by the ALF Administrator, Resident #1 and Resident #5's shared observed. On Resident #5's nightstand, 1 prescribed eye drop container for and one over the counter eye drop container was observed. An inquiry was made to the Administrator why these medications were not appropriately stored to which she stated she does not know how these medications got there and proceeded to put them in her pocket.

On at 11:18 AM after reviewing Resident #1 and Resident #5's records and Medication Observation Records (MOR) revealed Resident #1 and Resident #5 were not ordered eye drops of any kind. At this time, a request was made to the ALF Administrator to observe the eye drops again. The ALF Administrator proceeded to walk across the courtyard and into the dining/living and proceeded to open the top drawer of a bureau which was next to the locked medication cart and pulled out the 2 containers of eye drops. Review of the eye drops revealed they were prescribed for a male resident residing in the ALF and the eye drops were not labeled with any resident name. An inquiry was made to the ALF Administrator why she stored the 2 eye drops in the top drawer of the bureau situated right next to the medication cart, to which she stated when she took them out of the resident's did not have a key to the medication cart so she stored them in the drawer temporarily. Observation of the top drawer revealed napkin and table cloth storage. A further inquiry was made to the ALF Administrator who the unlabelled eye drops belonged to, to which she stated she did not know and further acknowledged she should not have put the medications in an unlocked drawer.

Review of the facility Medication Storage and Labeling Policy and Procedure states in part, 'All medications will be labeled in individual containers, clearly marked with resident's name, type and dosage of medication, physician's name, pharmacy name, date dispensed, and specific instructions on when medication should be taken. Over the counter medications must also be labeled as stated above.'

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965218	**06/15/2018**
NAME OF PROVIDER OR SUPPLIER **LAKEVIEW RETIREMENT RESIDENCE, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2304 NW 52ND COURT** **FORT LAUDERDALE, FL 33309**	

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

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 identify a resident who qualified for Limited Nursing Services (LNS), Resident #6, as evidenced by observation of Resident #6 with a right arm brace.

The findings include:
On [redacted] during the facility tour commencing at 9:50 AM with the ALF Administrator, Resident #6's living quarters was observed and sitting on top of the dresser in his [redacted] a right leg ankle/foot [redacted] (AFO) brace. An inquiry was made to the Administrator about the brace to which she stated the resident came in with the brace however does not like to wear it. Further during the tour at approximately 10:45 AM, Resident #6 was observed sitting in a wheelchair in the outside courtyard. Further observation revealed the resident was wearing a right arm brace. An interview was conducted with Resident #6 who confirmed he wore the brace daily and the aides help him put it on.

Review of Resident #6's record revealed he became a resident of the facility on [redacted] after sustaining a [redacted] accident resulting in right sided [redacted]. Review of the 1823 Resident Assessment dated [redacted] revealed documentation by the physician the resident wears a right AFO and uses a wheelchair for ambulation. Further review of the resident's record revealed no documentation of a right arm brace and no parameters for the use of the right arm brace.

On [redacted] at 12:55 PM an interview was conducted with the ALF Administrator and Licensed Practical Nurse (LPN) and an inquiry was made about the right arm brace and right AFO to which they stated the resident came in with the leg and arm brace. A further inquiry was made why Resident #6 was not included under LNS to which the ALF Administrator and LPN stated they did not know a resident with a brace would qualify for LNS.

Review of the facility Polices and Procedures for Limited Nursing Services (LNS) states in part, 'The following services may be provided by the ALF with a Limited Nursing Service license - Caring for casts, braces and [redacted]'

Class III

N277 - LNS - Resident Care Standards - 58A-5.031(2) FAC

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965218	06/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW RETIREMENT RESIDENCE, INC	**2304 NW 52ND COURT FORT LAUDERDALE, FL 33309**

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

Based on interview, record review and policy review the Assisted Living Facility (ALF) failed to obtain physician orders for LNS for 4 of 4 residents identified as receiving LNS services, Resident #1, Resident #2, Resident #3 and Resident #4, as evidence by no physician order for review in the resident's records.

The findings included:
1) Review of the facility LNS Log revealed Resident #1 was receiving LNS services for monitoring of [redacted] on an as needed basis. Further review of the LNS Log revealed no documentation of when the resident was admitted to LNS and no physician order for LNS services. Review of the clinical record for Resident #1 revealed no evidence of a physician order for LNS.

2) Review of the facility LNS Log revealed Resident #2 was receiving LNS services for monitoring of [redacted] on an as needed basis. Further review of the LNS Log revealed no documentation of when the resident was admitted to LNS and no physician order for LNS services. Review of the clinical record for Resident #2 revealed no evidence of a physician order for LNS.

3) Review of the facility LNS Log revealed Resident #3 was receiving LNS services for monitoring of [redacted] on an as needed basis. Further review of the LNS Log revealed no documentation of when the resident was admitted to LNS and no physician order for LNS services. Review of the clinical record for Resident #3 revealed no evidence of a physician order for LNS.

4) Review of the facility LNS Log revealed Resident #4 was receiving LNS services for monitoring of [redacted] on an as needed basis. Further review of the LNS Log revealed no documentation of when the resident was admitted to LNS and no physician order for LNS services. Review of the clinical record for Resident #4 revealed no evidence of a physician order for LNS.

On [redacted] at 12:28 PM an interview was conducted with the ALF Administrator and a request was made to provide the physician orders for the 4 residents identified as receiving LNS services in the LNS Log. The ALF Administrator stated in a shocked manner, "You have to have a physician order for LNS?'

Review of the facility Polices and Procedures for Limited Nursing Services (LNS) states in part, 'If a resident requires LNS, a written and signed order by the resident's primary healthcare provider will be kept in the resident's file. This will indicate the service(s) to be provided.'

On [redacted] at 12:45 PM, after reviewing the facility policy for LNS with the ALF Administrator, she stated it looks like she will have to refresh her memory of the LNS regulations and facility policies.

Class III