STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942934	06/22/2018
NAME OF PROVIDER OR SUPPLIER **GRAND COURT ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **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 licensure complaint survey, CCR# 2018004460, was conducted on and at Grand Court Assisted Living Facility License # 5464. The facility had a deficiency identified at the time of the survey.

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

Based on interview and record review, the facility failed to provide adequate supervision for 1 of 3 sampled residents (Resident # 1). The facility staff failed to observe the general health, safety and physical and emotional well-being of a resident after the Resident sustained a .

The findings included:

A review of Resident # 1 's file revealed an admission date of . Resident #1's Health Assessment form (AHCA form 1823) documents the following diagnosis: , , , Chronic Kidney , and . Resident is diagnosed as and disoriented. She requires supervision and basic nursing care. She requires assistance with bathing, dressing, self-care and toileting. She is independent with ambulation, eating and transferring.

Review of Resident #1's nursing observation notes dated revealed the following. Resident # 1 was found sitting on the floor (location was not documented) by the Certified Nursing Assistant (CNA). The Nurse on duty Staff A was notified. The nurse assessed the resident to have no open areas on her body. Staff A stated she assessed the Range of Motion (ROM) to the upper and lower extremities. She noted no complaints of pain or discomfort. The Physician was notified. The resident was assessed for a staff to remain on stand by to observe the resident.

Further review of the nursing observation notes documented the following. The facility physician was making general rounds on . The Physician gave new orders for , 500 mg, one tablet by mouth daily for 15 days; take the first dose today ( ). The physician order called for a X-ray 2 views left Knee, 2 views, for diagnosis of pain, An X-ray was ordered for the left Hip, 2 views for diagnosis of pain. The note stated the orders faxed to X-ray company (Name not noted in record) by Staff on duty.

A review of the nursing observation notes do not include any entries from - . The previous note dated indicates staff was ordered for stand by to monitor the resident. The observations of the resident was not documented to determine if resident showed signs or symptoms of

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pain. The stand by supervision was not conducted, as the Physician gave an order for medication and an X-ray for the diagnosis for pain conveyed by the Resident. The Staff was not aware of the Resident's condition.

Review of the nursing observation note dated revealed that the family of Resident # 1 was visiting the resident and noticed that the resident could not stand. The family member asked the staff about the X-ray results. The Nurse on duty (Staff B), then called the Physician's office regarding the physician order regarding the X-ray. The note states the family demanded that the facility send Resident # 1 out to the hospital via 911. The notes indicate the staff failed to follow-up on the X-ray order.

Observation notes dated documented that the Resident was hospitalized and sent to Rehabilitation during this period, (-). The medical records from the hospital reveal that Resident # 1 had sustained a Hip due to the . She was no longer able to ambulate independently. She was provided a wheelchair.

On at 03:00 PM, an interview was conducted with the Administrator. She stated all staff involved in this incident had been terminated as a result of the lack of supervision. She acknowledged the findings and indicated many changes have been implemented. She confirmed that the Staff were not aware that the resident was experiencing pain and discomfort. She stated if the staff had followed up on the X-ray order, the Resident could have been treated earlier.

Class III