Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969089	A. BUILDING: _____ B. WING _____	09/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHERIDAN AT COOPER CITY	2580 PINE ISLAND RD COOPER CITY, FL 33024

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced licensure complaint survey, #2019009303, was conducted on - , and at The Sheridan At Cooper City. The facility had a deficiency at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess appropriately for changes in conditions and contact the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change, for 1 of 3 sampled residents (Resident # 1). The findings included: On [redacted] at 2:28 PM, Resident # 1's closed record was reviewed. Resident # 1's date of admission [redacted] and discharge date [redacted]. The resident's Health Assessment AHCA 1823 dated [redacted] revealed a Medical History and Diagnoses of the following: [redacted], status post kyphoplasty, hyperkalemia, [redacted] ( ), [redacted] ( ), [redacted], Exacerbation, [redacted], and [redacted]. The Special Precautions is [redacted] (02)	A 025		

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A 025	Continued From page 2 pre re nata (PRN as needed). Resident # 1 's 72 Hour Observation notes was reviewed from the resident progress notes dated to . . . . Documented on the resident's private aid called Staff A and stated that the resident was experiencing , . . Resident # 1 was grimacing and said everything hurt. Staff A assessed the resident by giving PRN medication and monitored the resident. Resident # 1's progress notes documented . . . . at 1:14 PM were reviewed, the following was noted. On at 7:45 AM, the Private Aid pushed the alert button on Resident #1's . . in order to alert the nurse to come to the room. The staff from the floor received the alert and notified the nurse that the resident was in , . . At 7:55 AM, the nurse gave the resident Norco 5/325 mg tabs PRN for , . The medication was tolerated well by the resident. At 8:48 AM on . . . . , the Director of Memory Care requested that the daughter (POA) be given a call. She stated that Staff A will call at 10:00 AM. Staff A did not call the POA. The Private Duty Aid located Staff A while she was conducting a med pass. The Private Duty Aid Informed Staff A that Resident # 1's Physical . . , . . ( ) would like to speak with her. Staff A informed the Private Duty Aid that she was in the middle of a med pass and the could come and speak with her in the community. The Private Duty Aid stated that she would relay the message. The staff on duty located Staff A 10 minutes later and notified her that Resident #1 is experiencing , , related problems. Staff A went to Resident # 1's room and found the resident in the bed. The stated she took her vital signs and	A 025		

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A 025	Continued From page 3 she appears sick. Staff A gave the resident a . Staff A stated Resident # 1's was steady and strong, ( ) , Present Illness (PI) 114, resident is , skin is warm to touch, and temperature slightly elevated at 100.1 degrees. The indicated she contacted the POA and stated that the POA called the Emergency Medical Services ( ). arrived along with police officers. Staff A provided the following for Resident # 1: a brief history, copy of orders, and sheet. Staff A reported the findings to the Director of Memory Care. Review of documents provided by the facility throughout the survey revealed Staff A did not respond timely to the significant health changes regarding Resident #1. The staff also failed to appropriately monitor and assess and notify the resident's physician for further direction regarding the change in condition. Lastly, the facility records also failed to document the monitoring and follow-up regarding Resident #1 on . The facility also failed to investigate the delay of the assessment/monitoring of Resident #1 as voiced by the resident's family and private duty aid. On at 2:47 PM An interview was conducted with the Director of Memory Care. She was informed of the findings regarding the facility failure to assess and notify appropriate persons regarding Resident #1's change in condition. provider, and contact the POA. The Director of Memory Care acknowledged the findings and no additional information was provided. Class III	A 025		