STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964897	11/07/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Deer Creek	2403 West Hillsboro Blvd Deerfield Beach, FL 33442	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= J
St - A - 0029 - 58a-5.0182(5) Fac - Resident Care - Nursing Services S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= J
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0083 - 58a-5.0191(4) Fac - Training - First Aid And S-S= D
St - A - 0163 - 429.49 Fs - Records - Resident, Penalties For Alteration S-S= D
St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced licensure complaint survey, CCR#2014010566, was conducted on through and at Emeritus At Deer Creek. The facility had deficiencies found at the time of the visit.

This survey was conducted in conjunction with the follow-up visit to CCR#2014000144 on the same date. Please see separate report for findings.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on interview and record review, the facility failed to provide appropriate care and services to meet the needs of 1 of 3 residents (Resident #1) while residing in the facility.

The findings include:

Record review revealed Resident #1 was admitted to the facility on with diagnoses of Body , and a history of . His AHCA 1823 Assessment form, dated indicated he was alert to name and needed assistance with medical management and activities of daily living (ADL's). His record reflected he wore glasses and hearing aides.

The resident expired in the facility on . The resident resided in the facility . His service plan, was dated pre-admission, and updated on after he , the form was unsigned. The form reflected he was alert, oriented to person, could make self understood with clear ideas expressed, understood others, and could make safe decisions in familiar situations. It reflected he was unable to identify the name of the facility and needed occasional reminders to find areas in the community.

An interview with the assigned Aide A on at 3:04 PM, was conducted and revealed the resident

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964897	11/07/2014
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Emeritus At Deer Creek	2403 West Hillsboro Blvd Deerfield Beach, FL 33442	
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was able to make his needs known.

According to Aide A on at 7:45 AM, she entered his (Resident#1) provide morning care. She expressed the resident told her he felt as if he was having a and was guarding his side near his abdomen. He stated he did not feel well. She expressed she went and found the Med Tech and reported the resident's complaints to her. Aide A did not call 911. Aide A told the Med Tech to call 911. According to Aide A, she stated the Med Tech looked at the resident and indicated the pain was not in his chest area and made remarks indicating if 911 was called, it would pose a problem for her, and the family would be charged monies.

An interview with the Med Tech was conducted on at 11:00 AM. The Med Tech stated she was told by Aide A the resident was not feeling well and she went to see him. She stated the resident nodded his head indicating he was ok and she gave him his medications at 8:00 AM. The record reflected he received Levothryoxine and She did not call 911. She stated she was unable to find the nurse, however failed to provide details of steps she took to summon the nurse. There was no evidence found the Med Tech attempted to page the nurse on duty at the time. There was no evidence Aide A attempted to summon the nurse either. There were no attempts made to notify the physician or the daughter.

The interview with Aide A on at 3:04 PM revealed, she proceeded to provide morning care and the resident was perspiring. She stated she assisted him in the stand, and he was perspiring profusely. She reported the resident was "clammy" to the Med Tech. The Med Tech denied the resident was clammy per interview. Aide A indicated she told the Med Tech to call 911 again. There was no evidence found the staff attempted to summon the nurse at this time, nor call 911. The Resident was placed in the hallway in his wheelchair before 8:15 AM, according to Aide A.

An interview with the nurse on at 8:30 AM revealed, the nurse on duty arrived at the resident's 8:15 AM and performed an The results were 137. There was no further assessment of the resident's condition performed. The nurse revealed the actual time she performed the was around 8:00AM-8:30AM. She was unaware the resident complained to the staff about not feeling well, feeling as if he was having a and was perspiring. She stated no staff member notified her the resident expressed concerns, nor informed her he had been perspiring prior. The nurse stated she was paged by the Med Tech at approximately 9:00 AM the resident was unresponsive in the dining She stated she was unable to get a pulse and at that time. She stated when she arrived in the dining resident was "blue" and she could not elicit a response from him.

Further interview with Aide A on at 3:04PM revealed, she placed the resident outside his door after morning care, in order for a staff member to transport him downstairs to the dining

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964897	11/07/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Deer Creek	2403 West Hillsboro Blvd Deerfield Beach, FL 33442	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

breakfast at 8:30 AM daily, as was customary. Aide A expressed the Med Tech usually transports the resident to the dining . . . . . Aide A stated she did not transport the resident. The Med tech denied she transported the resident. She stated in interview on . . . . at 11:00 AM, she transported another resident to the dining . but was unable to supply the name of the other resident she assisted. The facility did not determine which staff member transported the resident, and therefore was unable to determine the resident's clinical condition at that time. The facility's investigation suggested another resident instead of a staff member, transported Resident #1, however the elevators are locked on the unit and only staff are able to open them for the residents.

The facility did not thoroughly investigate the events. Review of the facility's filed adverse report indicated the resident was transported to the dining . . . . . 8:50 AM, however, there was no proof found to support this time as accurate. Aide A also revealed during the , 3:04 PM interview she did not believe the nurse completed the . . . . . at 8:15 AM and said there was a discussion between her and the nurse regarding supplying a fictitious reading in an acceptable range. The nurse denied this conversation occurred.

Further interview with the Med Tech on . . . . at 11:00AM revealed she told the kitchen staff to feed the . . . . residents first, as Resident #1 was . Aide B, was present and commented to the staff in the dining . . . . . to the Med Tech, there was no need to feed the resident, as the resident was . . . . .

In an interview with Aide B on at 2:40 PM, she stated the resident did not look well when he arrived in the dining . . . . . She did not recall who transported him off the elevator when he arrived or what time he arrived. She expressed he was seated in his wheelchair at the table, with his head down and to the side. He was not slumped on the table as the adverse report documents. She stated she told the Med Tech, "Don't feed him, he is .

The Med Tech stated on at 11:00AM, the resident was unresponsive and she called the concierge to page the nurse. She did not call 911, nor did other staff. The Med Tech during the interview with the surveyor, stated she told the concierge to call 911. The concierge validated during an interview with the Administrator on . . . at 11:12 AM, he was notified by the Med Tech to page the nurse at 9:00 AM. He denied the Med Tech asked him to call 911.

During further interview with the med tech as noted on . . . 11:00 AM, the nurse on . . . at 8:30 AM and Aide A on . . at 3:04 PM, revealed the following events regarding Resident #1 in the dining . . . The nurse, as noted above, arrived in the dining . . . . . approximately 9:00 AM and found Resident #1 unresponsive with no pulse or . and the resident's color was "blue." She directed the Med Tech to take the resident up the elevator to his . . . wheelchair, to initiate .

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

Staff were unaware of the resident's code status. She called 911 and retrieved the resident's chart from the nurse's station to determine his code status, and went to his the second floor. The Med Tech summoned Aide A to assist her in the transport. Aide A stated she questioned the Med Tech why the resident was being removed in an emergency situation. The Med Tech revealed in her interview she realized this course of action was wrong after it occurred. The nurse stated to the surveyor, she "lost her head" in making the right decision for a resident who may need She expressed when she arrived in the dining saw the resident unresponsive, she was upset with staff to the point of tears, as she felt no one was intervening on behalf of the resident and were solely relying on her. She indicated she was covering the supervising nurse duties at the facility, along with the duties of a Med Tech on another unit in the facility, outside of the memory unit where Resident #1 resided and the incident occurred. The nurse expressed when she arrived in the resident's the paramedics were there assessing the resident. She informed them the resident had a in place. The paramedics contacted law enforcement. The concierge validated both the paramedics and law enforcement arrived at the facility by 9:15 AM. was not performed on the resident and he was pronounced by paramedics and law enforcement at 9:15 AM. The nurse reported law enforcement expressed the body could be removed. The resident's record reflected upon his body was to be sent to a cremation provider.

An interview with the Resident's physician on at 10:00 AM validated the physician was not notified of the resident's complaints beginning at 7:45 AM on but was made aware on later in the day, the resident was The physician stated he signed the certificate himself, and attributed cause of as He expressed he would have transferred the resident to the hospital for evaluation, if the clinical condition including the expression by the resident, about he felt he was having a would have been reported to him right away.

Review of the progress notes in the medical record recorded by the nurse of the events of began when the resident was returned to bed. The notes did not contain information about his condition prior to at 9:15 AM. There was no mention of the resident's condition or when and where he was actually found unresponsive. There was no mention staff transported him to the dining breakfast. The nurse stated she notified the Health and Wellness Director at home on

An interview with the Administrator and Health and Wellness Director (HWD) beginning on at 10:02AM and at 3:00PM, indicated the facility does not have a system in place to review deaths occurring in the facility as part of Quality Assurance measures. The HWD validated she was made aware the resident expired in the facility on Sunday, by the nurse. She expressed she was told the resident was found unresponsive in his The Administrator expressed he was made aware of the on He expressed he mentioned the resident's passing during a weekly telephone conference call with corporate staff the next day, He expressed a corporate staff

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Emeritus At Deer Creek	2403 West Hillsboro Blvd Deerfield Beach, FL 33442	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

member arrived at the facility on to investigate the case. The Administrator stated he was informed by the corporate staff member, as a result of the corporate investigation, it was mentioned about the resident in the dining breakfast and should be looked in to. This prompted him to investigate the details of the resident's
The Administrator, at this time, reported his investigation revealed Aide A and the Med Tech had knowledge of the resident complaining of not feeling well and measures were not taken on their part to meet the needs of the resident, as noted above. He became aware Aide A and Med Tech were involved in transporting the resident, while he was unresponsive, back to his They did not provide the information until asked. He validated the nurse did not reveal the entire account of the incident to administration until the was under review.

Aide A expressed on at 3:04PM to administration and to the surveyor during interview, she was pressured by the nurse, the Med Tech, and Aide B not not disclose the resident went to breakfast and was returned to his The nurse denied this to the surveyor. Aide B did not report to administration what she observed on until she was asked to disclose. Aide A during the interview with the surveyor, offered a voicemail cellphone message left on her personal phone to be heard. She stated she received the message after administration began questioning staff. The audible message revealed, "We have to say the same thing....about him coming down...doesn't know...didn't see him" Aide A expressed the message was sent to her by Aide B. The voice on the message was consistent with the voice of Aide B the surveyor heard during interviewing Aide B. Aide B was interviewed on at 2:40 PM. Aide A was interviewed by the surveyor on at 3:04 PM. The HWD validated Aide A, Aide B, the Med Tech, and the Nurse are mandatory reporters of neglect, and did not bring complete information forward, until asked.

The Administrator stated on at 3:00PM, the events of constituted an adverse incident which he reported to the Agency for Health Care Administration on He stated the nurse and Med Tech were suspended immediately, however Aide A and B were permitted to remain working in the facility. During the survey, the nurse and Med Tech were not on duty, however Aide A and Aide B were observed caring for the residents. When asked what preventative measures were put in place, the Administrator expressed he believed the situation was an incident and two staff directly involved were removed. He stated, Aide A was permitted to remain on duty due for "telling the truth" when asked.

The HWD expressed on at 10:02AM, she was planning to inservice staff, but had not had a formal plan in place. She began providing inservices after surveyor intervention. She attributed it to the prior week spent completing the investigation. The HWD began creating a formal inservice plan immediately after discussing the issue with the surveyor and inserviced (22) staff on The topics included as documented on sign-in sheets stated , Forms on Doors, Activating 911,

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

and Initiating . . . . On after inservicing 4 random 2PM-10PM staff members on duty were questioned about the inservice.

Record review showed (35) residents out of 152 had a . . . . . order in place. . . . . training with current certification of direct care staff was reviewed and expired . . . . training records were found. Aide A's . . . . training record expired on . . . . . .

Class I

0029-Resident Care - Nursing Services 58A-5.0182(5) FAC

Based an interview and record review, the facility failed to maintain progress notes involving a resident with a change in condition for 1 of 3 residents reviewed (Resident #1).

The findings include:

Resident #1 was admitted to the facility on . . . . . with diagnoses of . . . . . Body , and a history of . . . . . The resident expired in the facility on . The resident was at the facility . . . to . . . .

During interview with Aide A on . at 3:04PM, it was reported on . . . . . at 7:45 AM she entered resident #1's . . . . . provide morning care. She expressed the resident told her he felt as if he was having a . . . . . and was guarding his side near his abdomen. He stated he did not feel well. She expressed she went and found the Med Tech and reported the resident's complaints to her. Aide A told the Med Tech to call 911.

An interview with the Med Tech was conducted on . . . at 11:00 AM. The Med Tech stated she was told by Aide A the resident was not feeling well and she went to see him. She stated the resident nodded his head indicating he was okay and she gave him his medications at 8:00 AM.

The interview with Aide A on at 3:04PM revealed, she proceeded to provide morning care and the resident was perspiring. She reported the resident was "clammy" to the Med Tech. The Med Tech denied the resident was clammy. The aide indicated she told the Med Tech to call 911 again. The Resident was placed in the hallway in his wheelchair before 8:15 AM.

Interview with the nurse on . . . . at 8:30AM revealed, she arrived at the resident's . . . . . 8:15 AM and performed an . . . . . She reports, the Staff did not inform her of the resident's complaints or

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964897	11/07/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Deer Creek	2403 West Hillsboro Blvd Deerfield Beach, FL 33442	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

condition observed. The nurse stated she was paged by the Med Tech at approximately 9:00 AM, about the resident being unresponsive in the dining . . . . . She stated, she was unable to get a pulse and . at that time and the resident's color was found to be "blue."
The nurse directed the Med Tech to take the resident up the elevator to his . . . . . wheelchair to initiate . She called 911 and retrieved the resident's chart from the nurse's station to determine his code status, and went to his . . . . . the second floor. The Med Tech summoned Aide A to assist her in the transport. The resident was transported back to his . the two staff members and placed in the bed.

The progress notes dated . . . . . at 9:15 AM, written by the nurse states, "Resident found in bed in his . by . . . (Resident Assistant) and Med Tech. Resident assessed and checked for responsiveness, but resident is unresponsive. 911 activated immediately. When paramedics arrived to facility they pronounced resident expired. . . . not initiated due to . . . . order in chart. Family made aware and daughter states that she will come to the facility and spoke to sheriff, per daughter sheriff gave clearance for family to go ahead and contact (name) for funeral arrangements and to pick up resident."

The nurse was interviewed on . . . . . at 1:10 PM and . at 8:30 AM. She validated the progress notes did not reflect the resident's condition when she took his nor his condition in the dining . . . During the survey, the nurse offered to come to the facility during the investigation, although she was suspended, she would come to the facility and enter a late entry note. There was no late entry note found.

Interview with the Health and Wellness Director (HWD) on . 10:02 AM, and with the HWD and Administrator on . . . . . at 3:00 PM, were conducted. Both validated the progress notes did not contain the accurate account of the events, along with all pertinent details about his condition, on . involving Resident #1. They agreed progress notes were not maintained, as well as false reporting. The Administrator expressed there was no system in place to review for Quality Assurance measures, which would include a review of the notes, for . . . . . in the facility.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on interview and record review, the facility failed to ensure access to adequate and appropriate health care consistent with established and recognized standards within the community, as evidenced by a failure to call 911 or the Resident's physician, for a resident complaining to a staff member he may be experiencing a . . . . , for 1 of 3 residents reviewed, (Resident #1).

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964897	11/07/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Deer Creek	2403 West Hillsboro Blvd Deerfield Beach, FL 33442	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

The findings include:

Record review revealed Resident #1 was admitted to the facility on [redacted] with diagnoses of [redacted] Body [redacted] and a history of [redacted]. His AHCA 1823 Assessment form, dated [redacted] indicated he was alert to name and needed assistance with medical management and activities of daily living (ADL's).

The resident expired in the facility on [redacted]. The resident resided in the facility [redacted]. His service plan, was dated [redacted] pre-admission, and updated on [redacted] after he [redacted] the form was unsigned. The form reflected he was alert, oriented to person, could make self understood with clear ideas expressed, understood others, and could make safe decisions in familiar situations. It reflected he was unable to identify the name of the facility and needed occasional reminders to find areas in the community.

An interview with the assigned Aide A on [redacted] at 3:04 PM, was conducted and revealed the resident was able to make his needs known.

According to Aide A on [redacted] at 7:45 AM, she entered his (Resident#1) [redacted] provide morning care. She expressed the resident told her he felt as if he was having a [redacted] and was guarding his side near his abdomen. He stated he did not feel well. She expressed she went and found the Med Tech and reported the resident's complaints to her. Aide A did not call 911. Aide A told the Med Tech to call 911. According to Aide A, she stated the Med Tech looked at the resident and indicated the pain was not in his chest area and made remarks indicating if 911 was called, it would pose a problem for her, and the family would be charged monies. The Med Tech did not call 911. The Med Tech, designated to supervise the aide, did not contact the nurse nor call the resident's physician.

An interview with the Med Tech was conducted on [redacted] at 11:00 AM. The Med Tech stated she was told by Aide A the resident was not feeling well and she went to see him. She stated the resident nodded his head indicating he was ok and she gave him his medications at 8:00 AM. The record reflected he received Levothryoxine and [redacted] She did not call 911. She stated she was unable to find the nurse, however failed to provide details of steps she took to summon the nurse. There was no evidence found the Med Tech attempted to page the nurse on duty at the time. There was no evidence Aide A attempted to summon the nurse either. There were no attempts made to notify the physician or the residents family member.

The interview with Aide A on [redacted] at 3:04 PM revealed, she proceeded to provide morning care and the resident was perspiring. She stated she assisted him in the [redacted] stand, and he was

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964897	11/07/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Deer Creek	2403 West Hillsboro Blvd Deerfield Beach, FL 33442	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

perspiring profusely. She reported the resident was "clammy" to the Med Tech. The Med Tech denied the resident was clammy per interview. Aide A indicated she told the Med Tech to call 911 again. There was no evidence found the staff attempted to summon the nurse at this time, nor call 911. The Resident was placed in the hallway in his wheelchair before 8:15 AM, according to Aide A.

An interview with the nurse on . . . . . at 8:30 AM revealed, the nurse on duty arrived at the resident's . . . . . 8:15 AM and performed an . . . . . The results were 137. There was no further assessment of the resident's condition performed. The nurse revealed the actual time she performed the . . . . . was around 8:00AM-8:30AM. She was unaware the resident complained to the staff about not feeling well, feeling as if he was having a . . . . . and was perspiring. She stated no staff member notified her the resident expressed concerns, nor informed her he had been perspiring prior. The nurse stated she was paged by the Med Tech at approximately 9:00 AM the resident was unresponsive in the dining . . . . . She stated she was unable to get a pulse and . at that time. She stated when she arrived in the dining . . . . . resident was "blue" and she could not elicit a response from him.

Further interview with Aide A on . at 3:04PM revealed, she placed the resident outside his door after morning care, in order for a staff member to transport him downstairs to the dining . . . . . breakfast at 8:30 AM daily, as was customary. Aide A expressed the Med Tech usually transports the resident to the dining . . . . . Aide A stated she did not transport the resident. The Med tech denied she transported the resident. She stated in interview on . . . . . at 11:00 AM, she transported another resident to the dining . but was unable to supply the name of the other resident she assisted. The facility did not determine which staff member transported the resident, and therefore was unable to determine the resident's clinical condition at that time. The facility's investigation suggested another resident instead of a staff member, transported Resident #1, however the elevators are locked on the unit and only staff are able to open them for the residents.

In an interview with Aide B on . . . . . at 2:40 PM, she stated the resident did not look well when he arrived in the dining . . . . . She did not recall who transported him off the elevator when he arrived or what time he arrived. She expressed he was seated in his wheelchair at the table, with his head down and to the side. He was not slumped on the table as the adverse report documents. She stated she told the Med Tech, "Don't feed him, he is . . . . .

The Med Tech stated on . . . . . at 11:00AM, the resident was unresponsive and she called the concierge to page the nurse. She did not call 911, nor did other staff. The Med Tech during the interview with the surveyor, stated she told the concierge to call 911. The concierge validated during an interview with the Administrator on . . . . . at 11:12 AM, he was notified by the Med Tech to page the nurse at 9:00 AM. He denied the Med Tech asked him to call 911.

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

During further interview with the med tech as noted on 11:00 AM, the nurse on at 8:30 AM and Aide A on at 3:04 PM, revealed the following events regarding Resident #1 in the dining The nurse, as noted above, arrived in the dining approximately 9:00 AM and found Resident #1 unresponsive with no pulse or and the resident's color was "blue." She directed the Med Tech to take the resident up the elevator to his wheelchair, to initiate Staff were unaware of the resident's code status. She called 911 and retrieved the resident's chart from the nurse's station to determine his code status, and went to his the second floor. The Med Tech summoned Aide A to assist her in the transport. Aide A stated she questioned the Med Tech why the resident was being removed in an emergency situation. The Med Tech revealed in her interview she realized this course of action was wrong after it occurred. The nurse stated to the surveyor, she "lost her head" in making the right decision for a resident who may need She expressed when she arrived in the dining saw the resident unresponsive, she was upset with staff to the point of tears, as she felt no one was intervening on behalf of the resident and were solely relying on her. The nurse expressed when she arrived in the resident's , the paramedics were there assessing the resident. She informed them the resident had a in place.

An interview with the Resident's physician on at 10:00 AM validated the physician was not notified of the resident's complaints beginning at 7:45 AM on but was made aware on later in the day, the resident was The physician stated he signed the certificate himself, and attributed cause of as He expressed he would have transferred the resident to the hospital for evaluation, if the clinical condition including the expression by the resident, about he felt he was having a would have been reported to him right away.

Review of the progress notes in the medical record recorded by the nurse of the events of began when the resident was returned to bed. The notes did not contain information about his condition prior to at 9:15 AM. There was no mention of the resident's condition or when and where he was actually found unresponsive. There was no mention staff transported him to the dining breakfast. The nurse stated she notified the Health and Wellness Director at home on

An interview with the Administrator and Health and Wellness Director (HWD) beginning on at 10:02AM and at 3:00PM, both validated the staff should have called 911 immediately and notified the nurse. Both expressed staff are trained to call 911 for a resident and any staff member is permitted and advised to do so. Both the Administrator and HWD validated there were no attempts made to notify the physician. Both validated the resident was denied access to 911 services, as well as direction from his physician. Measures should have been taken when the resident said he felt like he was having a

During an interview on at 3:00 PM, The HWD expressed can also be initiated on any resident by staff, and then withdrawn when the chart retrieved reveals a She validated staff would not have a resident's to memory, and would have to go to the nurse's station on the first floor in an attempt to find out. She described the facility documents orders on a list kept behind the nurse's station door on

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

the first floor, as well as, each medical record contains the as the first page of the record. The outside binder of the record for a resident with a contains a hand-drawn black circle to indicate to staff the . She validated this was the only place in the entire facility information could be obtained. She stated staff should have called 911, then took measures to determine code status.

The facility's policies and procedures were reviewed for and . The policies do not contain details regarding what steps, including retrieving the resident's chart to check code status, as stated by the HWD, if a resident is found unresponsive. The facility consists of several floors and units as well as, a locked memory unit where Resident #1 resided. Access to the units from the first floor is provided by elevators and stairs. The facility has a capacity to hold 168 residents. The census during the survey was 152. Thirty five (35) residents were found to have orders.

Review of staff records revealed (22) direct care staff were not current with training, including Aide A.

Class I

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

Based on interview and record review, the facility failed to maintain an accurate Medication Observation Record (MOR) for 1 of 3 resident reviewed for medications (Resident #1).

The findings include:

Resident #1 was admitted to the facility on with diagnoses of , Body , and a history of . His AHCA 1823 Assessment form, dated , indicated he needed assistance with medication management. This was noted under the nursing requirements section. The resident received injections twice daily by the licensed nurse. The resident became unresponsive and expired in the facility on . The resident resided in the facility .

The resident was ordered as follows:

a) N 15 units (sq) every AM, along with R 16 units every AM.
b) N 4 units sq every evening and R 6 units sq every evening.
c) sugar monitoring twice daily before meals and at bedtime, with sliding scale coverage.

The MOR documented the time of administration for the AM as 6:30 AM. R was documented as 15 units every AM. The MOR documented the time for the before the breakfast meal as 6:30 AM. The MOR documented the resident received the and as written on the MOR, with the exception of the not administered on in the AM, as the

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964897	11/07/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Deer Creek	2403 West Hillsboro Blvd Deerfield Beach, FL 33442	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

resident expired in the facility.

An interview with the nurse, who cared for Resident #1 on was conducted on at 8:30 AM. She indicated the resident did not receive monitoring at 6:30 AM daily as the MOR documents, nor his N and R at 6:30 AM daily. She indicated the was done daily by a nurse around 8:00 AM to 8:30 AM, and the daily routine dose of the two was provided right before he ate his breakfast. This was between 8:30 AM and 9:00 AM daily.

A form entitled, "Daily Observation and Monitoring Worksheet" dated documented next to Resident #1's name, "Please check sugar and give right before meals per daughter."

The issue was brought to the attention of the Health and Wellness Director (HWD) on at 3:00PM, who validated what the nurse revealed regarding timing, as accurate. She expressed residents do not get or at 6:30 AM, they never have, and stated the MOR should indicate the correct times. She validated Resident #1's MOR was not accurate.
Further interview with the HWD revealed, as a result of the corporate investigation into the of Resident #1, she was made aware of medication errors found on his MOR and disciplined the nurse responsible on . The errors reported and subsequent disciplinary action that occurred, did not include the accuracy of time for the AM and monitoring, as noted above. The errors the corporate investigation revealed involved improper transcription of the sliding scale coverage, when the physician added a third monitoring at bedtime on and discovery that the physician originally ordered 16 units of R every AM as opposed to the transcribed 15 units. The order for 16 units was present on admission and was printed on a prescription. She validated the resident only received 15 units every AM daily during his stay, as the error was discovered after he expired.

Class III

0083-Training - First Aid and 58A-5.0191(4) FAC
Based on interview and record review, the facility failed to ensure current training was in place for 22 of 47 direct care staff members reviewed for training.

The findings include:

1. Resident Assistant A (also referred to as Aide A) date of hire was Her current training

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964897	11/07/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Deer Creek	2403 West Hillsboro Blvd Deerfield Beach, FL 33442	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

in her file had expired on . The Health and Wellness Director telephoned Aide A in front of the surveyor on . Aide A informed the HWD she had a more current training completed which expired however the information was not found in the facility. Aide A is a full time employee on the 6am-2pm shift.

2. Wellness Nurse date of hire was documented as . Her current training in her file expired on . The Wellness Nurse is a full-time employee, who oversees the staff and care of the residents, and is in charge in the absence of the Health and Wellness Director.

3. Licensed Practical Nurse (LPN) who works per diem every other weekend's on the 6am-2pm shift had training that expired on .

4. Resident Assistant B's date of hire was . The most current training expired on .

5. Resident Assistant C's date of hire was and works full time on 6am-2pm shift. The most current training expired on .

6. Resident assistant D's date of hire was and works part time, every other weekend, 2pm-10pm shift. The most current training expired on .

7. Resident Assistant E's date of hire was and works full time on 2pm-10pm shift. The most current training expired on .

8. Resident Assistant F's date of hire was and works part time on the 6am-2pm and 2pm-10pm shift. The most current training expired on .

9. Resident Assistant G's date of hire was and works part time on the 6am-2pm shift. The most current training expired on .

10. Resident Assistant H's date of hire was and works full time on 10pm-6am shift. The most current training expired on .

11. Resident Assistant I's date of hire was and works full time on the 6am-2pm shift. The most current training expired on .

12. Resident Assistant J's date of hire was and works part time on 6am-2pm and 2pm-10pm shifts. The most current training expired on .

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964897	11/07/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Deer Creek	2403 West Hillsboro Blvd Deerfield Beach, FL 33442	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

13. Resident Assistant K's date of hire was [redacted] and works full time 2pm-10pm shift. The most current [redacted] training expired on [redacted].

14. Resident Assistant L's date of hire was [redacted] and works full time 6am-2pm shift. The most current [redacted] training expired on [redacted].

15. Resident Assistant M's date of hire was [redacted] and works full time on 6am-2pm shift. The most current [redacted] training expired on [redacted].

16. Resident Assistant N's date of hire was [redacted] and works full time on 10pm-6am shift. The most current [redacted] training expired on [redacted].

17. Resident Assistant O's date of hire was [redacted] and works full time on 10am-6am shift. The most current [redacted] training expired on [redacted].

18. Resident Assistant P's date of hire was [redacted] and works full time on 6am-2pm and 2pm-10pm shifts. The most current [redacted] training expired on [redacted].

19. Med Tech Q's date of hire was [redacted] and works full time on the 6am-2pm shift. The most current [redacted] training expired on [redacted].

20. Med Tech R's date of hire was [redacted] and works full time 10am-6am. The most current [redacted] training expired on [redacted].

21. Med Tech S's date of hire was [redacted] and works part time every other weekend. The most current [redacted] training expired on [redacted].

22. Med Tech T's date of hire was [redacted] and works full time 6am-2pm shift. The most current [redacted] training expired [redacted].

The Administrator and Health and Wellness Director (HWD) validated the findings on [redacted] at 3:00PM. The Administrator stated the Human Resource (HR) Director was off the past week and at the time of the survey. The HR duties were not reassigned to another staff member, however the duties were being covered by the Administrator and the HWD. The Administrator called the HR director in front of the surveyor on [redacted]. The Administrator reported all the [redacted] information available at the facility was provided during the survey. The facility supplied the surveyor with an employee roster of all staff. The HWD verified the shift and position of each staff member found with noncompliance. The roster contained 98 staff members. Sixty staff on the list were identified as providing direct care and required

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964897	11/07/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Deer Creek	2403 West Hillsboro Blvd Deerfield Beach, FL 33442	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

to be current with documented in their personnel files. The HWD was only able to supply 47 records. This was confirmed with the Administrator who validated on these were the sum total of the records they were able to find during the survey.

Class III

0163-Records - Resident, Penalties for Alteration 429.49 FS
Based on interview and record review, the facility falsified the medical record regarding a resident found unresponsive in the facility, for 1 of 3 residents medical records reviewed (Resident #1).

The findings include:

Resident #1 was admitted to the facility on with diagnoses of Body and a history of The resident expired in the facility on He was found unresponsive in the dining the first floor between 8:30 AM and 8:50 AM.

During further interview with the med tech as noted on 11:00 AM, the nurse on at 8:30 AM and Aide A on at 3:04 PM, revealed the following events regarding Resident #1 in the dining The nurse, as noted above, arrived in the dining approximately 9:00 AM and found Resident #1 unresponsive with no pulse or and the resident's color was "blue." She directed the Med Tech to take the resident up the elevator to his wheelchair, to initiate Staff were unaware of the resident's code status. She called 911 and retrieved the resident's chart from the nurse's station to determine his code status, and went to his the second floor. The Med Tech summoned Aide A to assist her in the transport. Aide A stated she questioned the Med Tech why the resident was being removed in an emergency situation. The Med Tech revealed in her interview she realized this course of action was wrong after it occurred. The nurse stated to the surveyor, she "lost her head" in making the right decision for a resident who may need She expressed when she arrived in the dining saw the resident unresponsive, she was upset with staff to the point of tears, as she felt no one was intervening on behalf of the resident and were solely relying on her. The nurse expressed when she arrived in the resident's , the paramedics were there assessing the resident. She informed them the resident had a in place.

There was no documentation about the events that occurred in the dining , including the condition of no pulse, no unresponsive, and blue in color.
Review of the progress notes in the medical record recorded by the nurse of the events of began when the resident was returned to bed. The notes did not contain information about his condition prior to at 9:15 AM. There was no mention of the resident's condition or when and where he was

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964897	11/07/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Deer Creek	2403 West Hillsboro Blvd Deerfield Beach, FL 33442	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

actually found unresponsive. There was no mention staff transported him to the dining breakfast.

The progress note indicate he was found unresponsive in bed and 911 was activated immediately, however this was found to be inaccurate.

The progress notes dated at 9:15 AM, and written by the nurse states, "Resident found in bed in his by (Resident Assistant) and Med Tech. Resident assessed and checked for responsiveness but resident is unresponsive. 911 activated immediately. When paramedics arrived to facility they pronounced resident expired. not initiated due to order in chart. Family made aware ....."

The nurse was interviewed on at 1:10 PM and at 8:30 AM. She validated the progress notes did not reflect the resident's condition when she took his nor his condition in the dining There was no mention he complained of not feeling well to staff from 7:45 AM -8:15 AM on , and felt as if he was having a and perspiring, as reported by aide A on at 3:04PM. Interview with Aide A revealed a voicemail phone evidence demonstrating a staff member involved discussed not reporting the resident went to the dining The nurse offered to come to the facility during the investigation, although suspended, to enter a late entry note. There was no late entry note found.

Interview with the Health and Wellness Director (HWD) on , 10:02 AM, and with the HWD and Administrator on at 3:00 PM, were conducted both validated the progress notes did not contain the accurate account of the events, along with all pertinent details about his condition, on involving Resident #1. The nurse did not verbally report the sequence of events involving the dining them, when she notified the HWD at home on The Administrator expressed there was no system in place to review for Quality Assurance measures, which would include a review of the notes, for in the facility.

Class III

0165-Risk Mgmt & QA; Adverse Incident Report 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC
Based on interview and record review, the facility failed to ensure an internal risk management and quality assurance program was in place to assess resident care practices, involving the unexpected of a resident in the facility after 6 days of residency, and to identify quality deficiencies noted in A0025, A0029, A0030, A0054, A0083, and A0163 for 1 of 1 residents reviewed (Resident #1).

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964897	11/07/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Deer Creek	2403 West Hillsboro Blvd Deerfield Beach, FL 33442	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

The findings include:

Resident #1 was admitted to the facility on [redacted] with diagnoses of [redacted] Body [redacted] and a history of [redacted]. The resident expired in the facility on [redacted]. The resident was not on Hospice services.

In an interview with the Administrator on [redacted] at 1:00 PM, he identified the duties of risk management and Quality Assurance (QA) as "shared between us." He did not define "us" but indicated the Health and Wellness Director (HWD) was included. When asked if the facility's risk management and QA reviews include deaths in the facility, he stated "No." He expressed adverse incidents were reviewed regularly, but deaths were not reviewed for the potential of being an adverse incident. He noted, the resident resided in the facility for a total of 6 days.
The Administrator expressed he was made aware of the resident's [redacted] on [redacted]. He expressed he mentioned the resident's passing during a weekly, routine telephone conference call with corporate staff the next day, on [redacted]. He expressed a corporate staff member arrived at the facility on [redacted] to investigate the case. The Administrator stated he was informed by the corporate staff member, as a result of the corporate investigation, there was concern about the resident in the dining [redacted] breakfast. This prompted him to investigate the details of the resident's [redacted] and the staff practices on [redacted]. He was made aware the resident was found in bed in his [redacted] and upon hearing the resident was seen in the dining [redacted] breakfast appeared odd. As a result of his investigation, he expressed he felt Resident #1's case was an [redacted] incident and suspended two staff members to resolve the problem.

In an interview with the HWD on [redacted] she validated resident's [redacted] in the facility is not investigated unless care concerns are told to Administration, and indicated the facility has Hospice residents who expire in the facility ongoing. She indicated hospice deaths are expected and are not reviewed. The HWD validated Resident #1 was a new resident, residing for 6 days, and his [redacted] was not expected. She expressed administration was not provided, the accurate account regarding Resident #1's condition and sequence of events on [redacted] and staff failed to disclose an accurate account until they were asked directly. She validated the recorded progress notes were not maintained and the information documented on [redacted] was inaccurate.
She further explained as a result of the corporate investigation, transcription errors involving Resident #1's medications were found, but all errors were not uncovered. She validated staff were not aware of a resident's code status, until their record is reviewed, and/or staff find a resident's name on a list behind a door in the nurse's station on the first floor. The information was not documented in other places within the facility. The facility has several floors with elevator access and stairwells. The memory unit doors and elevator are locked and require a code from staff to enter. When the HWD was asked about emergency response for a resident with a [redacted] in place, she stated staff could perform [redacted] on anyone to

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964897	**11/07/2014**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Deer Creek	**2403 West Hillsboro Blvd Deerfield Beach, FL 33442**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

begin with, and at such time a _ _ _ _ is found, staff would stop the _ _ _ _.

Review of staff records revealed (22) direct care staff were not current with _ _ _ _ training.
On _ _ _ _ _ _ at 3:00PM, the Administrator indicated the responsibility of current _ _ _ _ training was the Human Resource Director.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Emeritus At Deer Creek
2403 West Hillsboro Blvd
Deerfield Beach, FL 33442

Dear Administrator:

This letter reports the findings of a complaint (CCR #2014010566) inspection survey conducted on , 2014, by a representative of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Corrective Actions numbered one (1) through three (3) of the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this hand delivered report, and with Corrections four (4) and five (5) within thirty (30) days of receipt.

The inspection resulted in findings of non-compliance in the following areas:
[delete 0000-Initial Comments and extra blank spaces from the tags cited list]

St - A - 0000 Initial Comments
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= J
St - A - 0029 - 58a-5.0182(5) Fac - Resident Care - Nursing Services S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= J
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0083 - 58a-5.0191(4) Fac - Training - First Aid And S-S= E
St - A - 0163 - 429.49 Fs - Records - Resident, Penalties For Alteration S-S= D
St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Directed Corrective Actions: [Delete unused rows or add rows if needed]

1. The Assisted Living Facility is required toaudit the records of each facility resident and compile an accurate list of residents with (hereinafter . Your facility must then designate locations for the list of residents and the residents' and implement a system for staff to identify whether a resident has a . This information must be communicated to direct care staff and the information must be accessible during each shift. This must be completed within 5 calendar days from the date of this letter.

2. The Assisted Living Facility is required to have a written policy on steps to take in emergency situations, including sudden illness of a resident. Your facility is directed to review and revise any current policies regarding emergency procedures, Do Not

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SlideShare.net/AHCAFlorida

Orders and resident to ensure they are consistent and do not contradict each other. The emerger policy must include:

Directions for staff on the initation of Pulonary (hereinafter unless a resident has a .
Directions on calling emergency personnel.
Directions on what staff in charge are to be notified and who are responsible for follow-up.
A plan for making all resident records (including medical records, medication records, resident emergency contacts and
available to direct care staff and emergency personnel, including. The location of the list of residents and the location of the hard copies of resident

This must be completed with **5 calendar days** from the date of this letter.

3. The Assisted Living Facility is required to train staff on the facility's emergency policies including, and policy and procedures after the policies are written/revised. A roster of these employees and written verification of the training and training materials must be available for AHCA staff to review. This must be completed within 5 calendar days from the date of this letter.

4. The Assisted Living Facility is required to obtain training from an outside, reputable source regarding honoring advance directives in an emergency situation. This training must be provided to your Administrator, Health and Wellness Director, and Wellness Nurse, and any other similar personnel. This training must then be provided to all staff. Documentation of training provided must be available for review by AHCA. The Administrator is responsible to ensure compliance. The curriculum and original certificates for this training must be retained by the facility in the employees' records and are to be available for review no more than thirty (30) days from the receipt of this letter.

5. The Assisted Living Facility is required to to provide training to all staff regarding maintaining accurate and thorough written resident records, including but not limited to training on updating records of any significant changes, any illnesses that resulted in medical attention, and other changes that resulted in the provision of additional services. The curriculum and original certificates for this training must be retained by the facility in the employees' records and are to be available for review no more than thirty (30) days from the receipt of this letter.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Emeritus At Deer Creek
, 2014

Should you have any questions, please call Tikel Wedges Phoenix, Health Facility Evaluator Supervisor.

Sincerely,

Arlene Mayo-Davis

Arlene Mayo-Davis
Field Office Manager

AMD/dmb D7JR

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