STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964897	**07/01/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
BROOKDALE DEER CREEK	**2403 WEST HILLSBORO BLVD DEERFIELD BEACH, FL 33442**	

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

0000 - Initial Comments

An unannounced Limited Nursing Services (LNS) Monitoring visit was conducted at Brookdale Deer Creek Assisted Living Facility on . . . . . The facility had a deficiency identified at the time of the visit related to LNS services.

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

Based on interview and record review, the facility failed to ensure clinical assessments were accurately documented and failed to provide timely management of , for 2 of 3 residents' records reviewed that are receiving Limited Nursing Services.

The Findings Include:

1) Resident #1 has resided in the facility since . . . . . with a diagnosis of . . . . . uropathy requiring a . . . . . He was admitted to LNS for the care and assessment of the . . . . . on . . . . .

Review of the record revealed LNS Progress Note completed by the Licensed Practical Nurse (LPN) dated . . . . . documenting a . . . . specimen was collected due to foul odor. Review of physician orders dated . . . . . documents 'Urinalysis, Culture & Sensitivity for a diagnosis of signs and symptoms of . . . . cloudy with strong ammonia odor.' Further review of the record revealed the results of the urinalysis was received by the facility on indicating the resident had a , and faxed to the resident's physician for review. Further review of the record revealed the results were re-faxed to the physician on four days after the initial fax transmission with no evidence of documentation why it took 4 days to follow up with the resident's physician to obtain treatment of the . . . . Review of the record revealed a physician order dated , 5 days after the receipt of the lab report, for . . . . . treatment for 7 days for the diagnosis of a . . . .

Further review of the twice daily LNS Progress Notes completed by the LPN revealed no further evidence of documentation of the appearance of the . . . . as initially documented on . . . . . as having a foul odor, cloudy in appearance.

On at 11:15 AM an interview was conducted with the LPN who documented the resident's . . . . had a foul odor on . . . . . She stated she brought it to the attention of the home health nurse who obtained the specimen and sent it to the lab. She stated in addition to the odor the . . . . was very cloudy. An inquiry was made for the reason it took 5 days to follow up and get a response from the physician to which she replied it had something to do with the home health and the results had to be re-faxed. She concurred there should have been a more timely follow up with the physician in addition they should have been documenting the appearance of the . . . . since he did have an

On . . . . . at approximately 12:00 PM an interview was conducted with the facility Wellness Coordinator who was unable to explain why it took 5 days to have the lab results reach the physician. She stated 5 days is a long time to wait for treatment of a . . . and it can be quite uncomfortable for the resident . . . one with a . . . . . .

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Further review of the record revealed a urinalysis was done on and reported by the lab on The results document the appearance of the is cloudy with many Further review of the record revealed a physician order dated for a 7 day course of treatment with for a diagnosis of Review of the twice daily LNS Progress Notes from through revealed no evidence of documentation of the appearance of the that required treatment.

During the interview with the Wellness Coordinator on at approximately 12:00 PM she concurred the nurses should have been documenting the appearance of the especially when the resident has a which makes them more susceptible to She stated she will re-educate the nurses on the importance of documentation.

2) Resident #2 has resided in the facility since with a diagnosis of knee replacement, and Review of the record revealed on the resident was diagnosed with having a per the lab results received by the facility and the lab results were faxed to the resident's physician on Further review of the record revealed a response from the physician was not received until 9 days after the results were initially faxed to the physician. The resident was started on for 14 days for the treatment of the Review of the record revealed no evidence of documentation for the delay in receiving treatment for the resident's

Further review of the record revealed Progress Notes dated documenting the resident was started on for 7 days for the treatment of a On and the resident was additionally started on treatment for 7 days for acquiring 6 from 2014 through March 2015. There is no evidence of documentation of the appearance of the resident's or any education regarding the prevention of Review of the record revealed no lab results to coincide with the initiation of treatments for the On at approximately 12:15 PM an interview was conducted with the Wellness Coordinator who after investigation stated the lab work was done in the resident's physician office and the office faxed over the prescription but not the lab results. She stated she has contacted the physician office to have them forward the lab results to the facility so they will have a complete record of the resident's status. She stated the resident is independent with toileting and they will initiate educating the resident on the prevention of

Further review of the record revealed Progress Notes dated the resident was experiencing and 3+ pitting to her lower extremities. The resident was hospitalized and returned to the facility on now on Further review of the Progress Notes revealed no documentation of the resident's status upon readmission to the facility from the hospital. Resident #2 was admitted to LNS for the monitoring of the use of

Review of the monthly LNS Nursing Assessment dated documents the resident had a significant change in condition during the past month, however, there is no documentation of the significant change on the assessment.

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Review of the monthly LNS Nursing Assessment dated documents the resident had a significant change in condition during the past month however there is no documentation of the significant change on the assessment.

Further review of the record revealed on the resident was started on for 7 days for the treatment of a the 7th documented since 2014. Review of the LNS Progress Notes revealed the resident was being assessed on a daily basis by the Licensed Practical Nurse (LPN) for the use of the however, there is no evidence of documentation of the resident's overall health status which could have an effect on her physical and mental status related to acquiring the and the use of for distress and/or

On at approximately 12:15 PM during the interview conducted with the facility Wellness Coordinator, she could not explain why the resident has had so many and concurred that the resident's overall status should be assessed along with the monitoring of the She could not explain why the nurse documented on the Monthly Nursing Assessment there was a significant change in the resident's status but did not document what the significant change was. She stated the nurses will be re-educated on the importance of documentation.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

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

RE: Limited Nursing Services (LNS)

Dear Administrator:

This letter reports the findings of a State Licensure Survey that was conducted on , 2015 by representative from this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please forward documentation of correction to the Field Office within ten business days of the date of this letter.** Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. Should you have any questions please call this office at (561) 381 - 5840.

Sincerely,

Arlene - Davis
Field Office Manager

AMD/jw
Enclosure

XG90

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