STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966324	01/11/2017
NAME OF PROVIDER OR SUPPLIER **CORAL SPRINGS COUNTRY CLUB FOR SENIORS**	STREET ADDRESS, CITY, STATE, ZIP CODE **2903 NW 115TH TERRACE** **CORAL SPRINGS, FL 33065**	

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

0000 - Initial Comments

An unannounced biennial relicensure survey was conducted on 01/11/2016 at Coral Springs Country Club for Seniors (License #10582). The facility had deficiencies at the time of the visit.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview the facility failed to ensure that 1 of 2 (Resident #3) residents' records reviewed addressed nursing services required by the individual.

The findings include:

A review of Resident #3's record reveals her admission date was / and her AHCA form #1823 dated reveals her her diagnosis includes: , body , and history of . Section 1 under nursing/treatment/ service requirements: indicates Hospice care only. A review of the "Hospice General Information and Instructions" dated / indicates under the heading "Tubes- Type: , with the date the was inserted, blank.
In an interview conducted on / / at 11:53 AM with Staff A, she stated that Resident #3 currently has a . In an interview conducted on / / at 01:35 PM with Staff C, she also stated that Resident #3 currently has a .
In an interview conducted on / / at 2:45 PM with the Administrator, she confirmed that Resident #3 has a , she further stated that when she assessed the resident at the hospice unit, the resident did not have a ,but when she arrived to the facility, she already had the .
In an interview conducted on / /7 at 1:49 PM with the hospice nurse, she confirmed that there is no order for the , if there is a problem the facility staff would call the emergency number and she would come out, she comes out once per week, if she has to come out to change it she does, weekly she just checks it. She further stated that Resident #3 has had the inserted since at least when she started in 2016.
A review of the "Initial Integrated Plan of Care" dated reveals that the plan lacked any reference to the or care, and also lacked signature by facility staff.

In an interview conducted on / at 2:19 PM with a representative for Resident #3, she confirmed that the resident did have a inserted, and that she had it inserted a couple of days prior to admission to the facility, and that Resident #3 was unable to maintain it without the assistance of a nurse.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966324	01/11/2017
NAME OF PROVIDER OR SUPPLIER **CORAL SPRINGS COUNTRY CLUB FOR SENIORS**	STREET ADDRESS, CITY, STATE, ZIP CODE **2903 NW 115TH TERRACE CORAL SPRINGS, FL 33065**	

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

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

Based on record review and interview, the facility failed to ensure that 1 of 2 (Resident #3) residents reviewed, coordinated with third party services regarding the resident ' s condition and the services being provided.

The findings include:
A review of Resident #3's record reveals her admission date was and her AHCA form #1823 dated reveals her her diagnosis includes: , body , and history of . Section 1 under nursing/treatment/ service requirements: indicates Hospice care only. A review of the "Hospice General Information and Instructions" dated indicates under the heading "Tubes- Type: , with the date the was inserted, blank.
In an interview conducted on / / at 11:53 AM with Staff A, she stated that Resident #3 currently has a . In an interview conducted on / / at 01:35 PM with Staff C, she also stated that Resident #3 currently has a .
In an interview conducted on / /7 at 2:45 PM with the Administrator, she confirmed that Resident #3 has a , she further stated that when she assessed the resident at the hospice unit, the resident did not have a ,but when she arrived to the facility, she already had the . She was unable to state when the was inserted or what is the facility's responsibility for the .
In an interview conducted on / /7 at 1:49 PM with the hospice nurse, she confirmed that there is no order for the , if there is a problem the facility staff would call the emergency number and she would come out, she comes out once per week, if she has to come out to change it she does, weekly she just checks it. She further stated that Resident #3 has had the inserted since at least when she started in 2016, and that there is no care plan for the .
A review of the "Initial Integrated Plan of Care" dated reveals that the plan lacked any reference to the or care, and also lacked signature by facility staff.
In a subsequent interview with the hospice nurse conducted on / / at 2:44 PM, she stated that she received an order to discontinue the on today.
In an interview conducted on / / at 2:19 PM with a representative for Resident #3, she confirmed that the resident did have a inserted, and that she had it inserted a couple of days prior to admission to the facility and that Resident #3 was unable to maintain it without the assistance of a nurse.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

Administrator
Coral Springs Country Club For Seniors
2903 NW 115th Terrace
Coral Springs, FL 33065

RE: Relicensure survey

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 12 and 23, 2017 by a representative of 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 attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2017.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 Mayo-Davis
Field Office Manager

AMD/dso
Enclosure
XG90

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