STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969092	11/01/2018
NAME OF PROVIDER OR SUPPLIER **SYMPHONY AT THE WATERWAYS**	STREET ADDRESS, CITY, STATE, ZIP CODE **3001 E OAKLAND PARK BLVD** **FORT LAUDERDALE, FL 33306**	

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

0000 - Initial Comments

An unannounced Limited Nursing Services (LNS) monitoring survey was conducted on at Symphony at the Waterways, License # 12940. The facility had LNS deficiencies at the time of the visit.

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

Based on observation, interview and record review, the facility failed to ensure nursing services provided were conducted and supervised in a manner prevailing in the nursing community. This was evidenced by the failure to follow prescribed health care provider orders for 6 of 6 sampled residents, (Residents #1-#6) receiving Limited Nursing Services (LNS).

The findings include:

In an interview with the Director of Health and Wellness on 11/ at 10:30 AM, she stated that 6 residents, #1- #6 were receiving LNS care from the facility.

1. Review of Resident #1's medical record indicated the resident was admitted to LNS on with a health care provider order for ( ) 2 liters (L) by nasal cannula at night, to begin at 11:30 PM and removed at 7:30 AM. Review of facility electronic Medication Observation Record (EMOR) for 2018 indicated nursing staff documentation that O2 was" given in AM and PM" with no further documentation as to time of the application and removal as per order. Review of a progress note dated on indicating the resident was complaining of not getting adequate flow thru the tubing and the nurse replaced the tubing. The note further indicated that Resident #1's saturation rate (SAT) was 98% and monitoring would be continued by the nurse. Review of the progress notes indicated no additional monitoring or notes completed. In an interview with Resident #1 on at 11:35 AM she stated that she has issues, which she requires the use of at night. Resident #1 stated that most of the time she is applies the herself.

2. Review of Resident #2's medical record indicated the resident was admitted to LNS on with a health care provider order of compression stockings for lower extremity and monitoring of a on the resident's left lower leg. Further review of the order indicated the stockings were to be applied in the morning and removed at night. The order indicated that a Home Health Agency nurse would primarily be performing the care and facility nursing staff as needed. Review of facility progress notes indicated the last note documenting an observation of the left leg was on , no additional notes were available for review. Review of Resident #2' s service agreement dated indicated the resident requires "much help with dressing herself ". Review of the facility

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EMOR for 2018 indicated that the facility had not been applying the compression hose as ordered. In an interview with Director at 12:15 PM she stated that she requests a verbal report from the Home Health nurse weekly, but she had not documented any details of the condition and progress. She stated that she had no access to home health agency notes for review. The Director confirmed that no documentation had been completed for the compression stockings. In an interview with Resident #2 on at 11:25 AM, she was observed outside sitting on the patio and both her feet were observed edematous, no compression stockings had been applied. Resident #2 stated that staff does not apply stockings and the on her left lower leg was healed.

3. Review of Resident #3's medical record indicated the resident was admitted to LNS on with a health care provider order for compression stockings placement daily and care, to change the wafer as needed. Review of the facility progress notes and EMOR indicated no documentation of compression stocking application or any monitoring of the site. In an interview with Resident #3 on at 11:40 AM he was observed outside sitting on the patio, no stockings were observed in place. Resident #3 stated that he cares for his site and changes the bag himself. He stated that facility nurses have not been assisting him and at times he has difficulty with performing his ostomy care.

4. Review of Resident #4's medical record indicated the resident was admitted to LNS on with a health care provider order for resident self catherization 3 times a day for retention. The order also included facility nursing assistance with as needed. Further review of the orders indicated the use of an Arizona walking every day for a healing of the left foot. Review of facility EMOR indicated the placement daily and no progress notes for monitoring of the . Review of the progress notes indicated no monitoring of resident self catherization or monitoring for retention by nursing staff. In an interview with Resident #4 on at 11:05 AM he stated that he performs self at least 3 times daily and the Director had assisted him to insert a a few weeks ago. Further review of facility progress notes indicted no documentation of the assistance.

5. Review of Resident #5's medical record indicated the resident was admitted to LNS on with a health care provider order for compression stocking placement in morning and removal at night for . Review of an additional physician order dated on indicated to empty the "PleraX" (drain) every 7 days. Review of progress notes for 2018 indicated one note on which documented the drain site. Review of the and 2018 EMOR indicated no documentation of the compression stocking application and removal. Review of Resident #5's hospital record dated on indicated the resident had a medical diagnosis of and ( ). Review of Resident #5's report

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SUMMARY STATEMENT OF DEFICIENCIES
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dated on indicated recurrent , of the left chest , and insertion of a left PleurX chest tube . Review of facility "outside provider visitation notes"dated from - indicated the Home Health Agency nurse was performing , drainage weekly . Review of the facility nursing progress notes indicated no documentation of observation of the , drain site. Further review of Resident #5's medical record indicated he was placed on hospice services starting and a hospice order dated which indicated to discontinue weekly , drainage and start every other week. Review of facility records indicated no observations noted on the EMOR or progress notes for the stockings or observation of the , drain site . In an interview with Resident #5's spouse on at 11:20 AM stated that Resident #5 does not like the compression stockings and has not been using them, since the in the lower extremities has decrease with the use of , drainage. Resident #5's spouse stated the resident has been itching and scratching at the drain site/ dressing.In an interview with Director at 12:15 PM confimed that facility nursing staff have not been documenting any observations of the drain site for signs of .

6. Review of Resident #6's medical record indicated the resident was admitted to LNS on with a health care provider order for compression stockings placement daily for . Review of 2018 EMOR indicated the stockings as "given" daily. Review of facility progress notes indicated no nursing observation /monitoring for . In an interview with Resident #6 on at 11:30 AM she stated that sometimes she puts her own stockings on, compression stockings were observed in place at time of interview.

Class III

N278 - LNS - Records - 58A-5.031(3) FAC; 429.07 (3)(c)2, FS

Based on observation,interview and record review, the facility failed to maintain the required documentation requirements for Limited Nursing Services (LNS). This was evidenced by the failure to maintain the nursing progress and monthly assessment care notes for 6 of 6 sampled residents, (Residents #1- #6) receiving Limited Nursing Services.

The findings include:

In an interview with the Director of Health and Wellness on 11/ at 10:30 AM, she stated that 6 residents, #1- #6 were receiving LNS care from the facility.

1. Review of Resident #1's medical record indicated the resident was admitted to LNS on with a health care provider order for ( ) 2L by nasal cannula at night, to be placed on at 11:30 PM

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SUMMARY STATEMENT OF DEFICIENCIES
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and removed at 7:30 AM. Review of facility electronic Medication Observation Record (EMOR) for 2018 indicated nursing staff documentation of O2 was" given" in AM and PM with no further documentation as to time of the application and removal as per order. Review of the progress notes indicated a note dated on indicating the resident was complaining of not getting adequate flow thru the tubing and the nurse replaced the tubing. The note further indicated that Resident #1's saturation rate (SAT) was 98% and monitoring would be continued by the nurse. Review of the progress notes indicated no additional monitoring or notes completed and the required monthly LNS nursing assessment had not been completed. In an interview with Resident #1 on at 11:35 AM she stated that she has issues, which she requires the use of at night. Resident #1 stated that most of the time she is applies the herself.

2. Review of Resident #2's medical record indicated the resident was admitted to LNS on with a health care provider order for compression stockings for lower extremity and monitoring of a on the left lower leg. Review of the order indicated the stockings to be applied in the morning and removed at night. The order indicated that a Home Health Agency nurse would primarily perform the care and facility nursing staff as needed. Review of facility progress notes indicated the last note documenting the left leg was on , no additional notes were available for review. Review of the facility EMOR for 2018 indicated that the facility had not been applying the compression hose as ordered. In an interview with Director at 12:15 PM she stated that she requests a verbal report from the Home Health nurse weekly, but she had not documented any details of the condition/progress. She stated that she had no access to home health agency notes for review. The Director confirmed that no documentation had been completed for the compression stockings and the required monthly LNS nursing assessment had not been completed. In an interview with Resident #2 on at 11:25 AM, she was observed outside sitting on the patio and both her feet were observed edematous, no compression stockings had been applied. Resident #2 stated that staff does not apply stockings and the on her left lower leg was healed.

3. Review of Resident #3's medical record indicated the resident was admitted to LNS on with a health care provider order for compression stockings placement and care to change wafer as needed. Review of the facility progress notes and EMOR indicated no documentation of compression stocking application or any monitoring of the site. Additionally the required monthly LNS nursing assessment had not been completed. In an interview with Resident #3 on at 11:40 AM he was observed outside sitting on the patio, no stockings were observed in place. Resident #3 stated that he cares for his site and changes the bag, He stated that facility nurses have not been assisting him and that at times he has difficulty with performing ostomy care.

4. Review of Resident #4's medical record indicated the resident was admitted to LNS on with

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a health care provider order for resident self catherization 3 times a day for retention. The order also included facility nursing assistance with as needed. Further review of the orders indicated the use of an Arizona walking every day for of the left foot. Review of facility EMOR indicated the placement daily and no progress notes for monitoring. Review of the progress notes indicated no monitoring for resident catherization or retention by nursing staff. Additionally the required monthly LNS nursing assessment had not been completed. In an interview with Resident #4 on at 11:05 AM he stated that he performs self at least 3 x daily and the Director had assisted him to insert a . Further review of facility progress notes indicted no documentation of the assistance.

5. Review of Resident #5's medical record indicated the resident was admitted to LNS on with a health care provider order for compression stocking placement in morning and removal at night for . Review of an additional physician order dated on indicated to empty the PleraX (drain) every 7 days. Review of progress notes for 2018 indicated one note on which documented the drain site. Review of the and 2018 EMOR indicated no documentation of the compression stocking application and removal. Review Resident #5's Hospital record dated on indicated the resident had a medical diagnosis of , and ( ) exacerbation. Review of Resident #5's report dated on indicated recurrent of the left chest, and insertion of a left PleurX chest tube . Review of facility "outside provider visitation notes"dated from - indicated the Home Health Agency nurse was performing drainage weekly. Review of the facility nursing progress notes indicated no documentation of observation of the drain site. Further review of Resident #5's medical record indicated he was placed on hospice services starting and a hospice order dated which indicated to discontinue weekly drainage and start every other week. Review of facility records indicated no observations noted on the EMOR or progress notes for the stockings or observation of the drain site. And additionally the required monthly LNS nursing assessment had not been completed. In an interview with Resident #5's spouse on at 11:20 AM stated that Resident #5 does not like the compression stockings has not been using them, since the in the lower extremities has decrease with the use of drain. Resident #5's spouse stated the resident has been itching and scratching at the drain site/ dressing.In an interview with Director at 12:15 PM confimed that facility nursing staff have not been documenting any observations of the drain site for signs of .

6. Review of Resident #6's medical record indicated the resident was admitted to LNS on with a health care provider order for compression stockings use daily for . Review of 2018 EMOR indicated the stockings as given daily. Review of facility progress notes indicated no nursing observation /monitoring for . Review of the medical record indicated no required monthly LNS

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nursing assessment had not been completed. In an interview with Resident #6 on at 11:30 AM she stated that sometimes she puts on her own stockings, compression stockings were observed in place at time of the interview.

Class III