

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MERRIMENT MANOR RETIREMENT HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1835 WILSON STREET HOLLYWOOD, FL 33020		
(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 Assisted Living Facility complaint survey (CCR#2012012279) was conducted on Merriment Manor Retirement Home, had licensure deficiencies found at the time of the visit .	A 000		
A 004	58A-5.016 FAC Licensure - Requirements License Requirements. (1) SERVICE PROHIBITION. An ALF may not hold itself out to the public as providing any service other than a service for which it is licensed to provide. (2) LICENSE TRANSFER PROHIBITION. Licenses are not transferable. Whenever a facility is sold or ownership is transferred, including leasing, the transferor and transferee must comply with the provisions of Section 429.41, F.S., and the transferee must submit a change of ownership license application pursuant to Rule 58A-5.014, F.A.C. (3) CHANGE IN USE OF SPACE REQUIRING CENTRAL OFFICE APPROVAL. A change in the use of space that increases or decreases a facility's capacity shall not be made without prior approval from the Agency Central Office. Approval shall be based on the compliance with the physical plant standards provided in Rule 58A-5.023, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation requirements as referenced in Rule 58A-5.0161, F.A.C. (4) CHANGE IN USE OF SPACE REQUIRING FIELD OFFICE APPROVAL. A change in the use of space that involves converting an area to resident use, which has not previously been inspected for such use, shall not be made without prior approval from the Agency Field Office. Approval shall be based on the compliance with	A 004		

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

41HI11

If continuation sheet 1 of 13

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
---	--	--	-------------------------------

NAME OF PROVIDER OR SUPPLIER MERRIMENT MANOR RETIRMENT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1835 WILSON STREET HOLLYWOOD, FL 33020
---	--

(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 004	Continued From page 1 the physical plant standards provided in Rule 58A-5.023, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation standards as referenced in Rule 58A-5.0161, F.A.C. (5) CONTIGUOUS PROPERTY. If a facility consists of more than one building, all buildings included under a single license must be on contiguous property. "Contiguous property" means property under the same ownership separated by no more than a two-lane street that traverses the property. A licensed location may be expanded to include additional contiguous property with the approval of the agency to ensure continued compliance with the requirements and standards of Part I, Chapter 429, F.S., and this rule chapter. (6) PROOF OF INSPECTIONS. A copy of the annual fire safety and sanitation inspections described in Rule 58A-5.0161, F.A.C., shall be submitted annually to the Agency Central Office. The annual inspections shall be submitted no later than 30 calendar days after the inspections. Failure to comply with this requirement may result in administrative action pursuant to Section 429.14, F.S., and Rule 58A-5.033, F.A.C. (7) MEDICAID WAIVER RESIDENTS. Upon request, the facility administrator or designee must identify Medicaid waiver residents to the agency and the department for monitoring purposes authorized by state and federal laws. (8) THIRD PARTY SERVICES. (a) In instances when residents require services from a third party provider, the facility administrator or designee must take action to assist in facilitating the provision of those services and coordinate with the provider to meet the specific service goals, unless residents or their representatives decline the assistance. The declination of assistance must be reviewed at	A 004		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
---	--	--	-------------------------------

NAME OF PROVIDER OR SUPPLIER MERRIMENT MANOR RETIRMENT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1835 WILSON STREET HOLLYWOOD, FL 33020
---	--

(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 004	Continued From page 2 least annually. These actions must be documented in the resident ' s record. (b) In instances when residents or their representatives arrange for third party services, the facility administrator or designee, when requested by residents or representatives, must take action to assist in facilitating the provision of those services and coordinate with the provider to meet the specific service goals. These actions must be documented in the resident ' s record. (c) The facility ' s facilitation and coordination as described under this subsection does not represent a guarantee that residents will receive third party services. If the facility ' s efforts at facilitation and coordination are unsuccessful, the facility should include this documentation in the resident ' s record, explaining the reason or reasons its efforts were unsuccessful, which will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to submit proof of a current fire safety inspection as required by Section 429.14, F.S. and Rule 58A-5.033, F.A.C. The findings include: During a review of the facility's fire inspection reports, it was revealed that the Fire Safety inspection report was not in compliance with Section 429.14, F.S. requiring the Fire Safety inspection report not to be more than one year old and submitted to the Agency Central Office. It was noted the most current Fire Safety inspection report was dated _____, nearly two years old. In an interview with the Administrator on _____	A 004		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
---	--	--	-------------------------------

NAME OF PROVIDER OR SUPPLIER MERRIMENT MANOR RETIREMENT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1835 WILSON STREET HOLLYWOOD, FL 33020
--	--

(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 004	Continued From page 3 at 10:45 AM, she agreed that the Fire Safety inspection was not correct and that the facility had not submitted the report to the Agency, as required. Class III	A 004		
A 081 SS=D	58A-5.0191(2) FAC Training - Staff In-Service (2) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with Rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions, and facility sanitation procedures before providing personal care to residents. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to blood borne may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting major incidents. 2. Reporting adverse incidents. 3. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility.	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MERRIMENT MANOR RETIREMENT HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1835 WILSON STREET HOLLYWOOD, FL 33020		
(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 081	Continued From page 4 2. Recognizing and reporting resident neglect, and (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with Rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based upon record review and interviews it was determined that the facility failed to ensure that its employees completed the required training for 1 out of 3 sampled employees (Employee #2). The findings include: A review of employee #2's file revealed no	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
---	--	--	-------------------------------

NAME OF PROVIDER OR SUPPLIER MERRIMENT MANOR RETIREMENT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1835 WILSON STREET HOLLYWOOD, FL 33020
--	--

(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 081	Continued From page 5 documentation that employee #2 completed the required neglect, _____ and _____ training and the resident rights training. An interview was conducted with the facility Administrator on _____ at approximately 3:56 PM, during which she confirmed the findings. Class III	A 081		
A 083 SS=D	58A-5.0191(4) FAC Training - First Aid and _____ (4) FIRST AID AND _____ _____ A staff member who has completed courses in First Aid and _____ and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation of attendance at First Aid or _____ course offered by an accredited college, university or vocational school; a licensed hospital; the American Red Cross, American _____ Association, or National Safety Council; or a provider approved by the Department of Health, shall satisfy this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under Part III of Chapter 401, F.S., shall be considered as having met the training requirements for both First Aid and _____ This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure that atleast one staff member is present in the facility at all times that has current _____ certification, for 1 out	A 083		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
---	--	--	-------------------------------

NAME OF PROVIDER OR SUPPLIER MERRIMENT MANOR RETIRMENT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1835 WILSON STREET HOLLYWOOD, FL 33020
---	--

(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 083	Continued From page 6 of 3 sampled employees (Employee #2). The findings include: Record review of Employee #2's file revealed the file lacked documentation indicating the employee had received current training in An interview with the Administrator at 1 PM on revealed each employee works alone and no other staff member present. Further interview with the Administrator revealed she did not have documentation indicating the noted employees had current certification.	A 083		
A 092 SS=E	Class III 58A-5.020(1) FAC Food Service - General Responsibilities Food Service Standards. (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator or a person designated in writing by the administrator shall: (a) Be responsible for total food services and the day to day supervision of food services staff. (b) Perform his/her duties in a safe and sanitary manner. (c) Provide regular meals which meet the nutritional needs of residents, and therapeutic diets as ordered by the resident 's health care provider for resident 's who require special diets. (d) Maintain the in-service and continuing education requirements specified in Rule 58A-5.0191, F.A.C.	A 092		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MERRIMENT MANOR RETIRMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 WILSON STREET HOLLYWOOD, FL 33020		
(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 092	Continued From page 7 This Statute or Rule is not met as evidenced by: Based upon observation record review and interviews it was determined that the facility failed to perform food service duties in a safe and sanitary manner. The findings include: Tour of the facility was conducted on _____ at 9:45 AM and revealed the following related to the kitchen: a) Three refridgerators that were observed to be extremely filthy on the interiors b) Chicken was placed on the middle shelf to be defrosted above a large container of open leftover pasta, several loaves of bread and vegetables in refrigerator #1. c) 8 loaves of expired bread in refrigerator #1. d) 3 1/2 half gallon sized bottles of expired yogurt in refrigerator #3 e) 1 container of cooked egg which appeared to be scrambled left uncovered in refrigerator #1. The container was observed to be undated. f) The three refrigerators were observed to be stocked; 1 1/2 gallon milk, 1 1/2 bags of carrots 1 sausage, 2 1/2 dozen of eggs, 2 bags shredded cabbage, container of left over pasta sauce, 1/2 bottle of grape jelly, 2 pints ice cream 2 packs frozen potatoes. An interview with the Assistant Administrator revealed that the facility buys food as needed for the residents. g) 1 container of onions on the counter was observed to have green mold like substance and multiple flies that were living in the bottom of the container. The onions were observed sprouting. h) 1/2 bottle of lemon juice was observed in the cupboard the bottle had the words "refrigerate after opening" printed on the label.	A 092			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MERRIMENT MANOR RETIREMENT HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1835 WILSON STREET HOLLYWOOD, FL 33020		
(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 092	Continued From page 8 i) A dirty fan was observed blowing dust onto clean glasses which were observed lying flat on the side on rack in the kitchen. The rack was observed to contain other unclean items belonging to staff members such as purses and used water bottles. j) staff member was observed washing dishes and was observed to be unaware that she needed to use test strips to measure the amount of sanitizer in the water. An interview with the Food Service Manager revealed that he was unaware that the water needed testing daily or at each use. Class III	A 092		
A 093 SS=D	58A-5.020(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The Tenth Edition Recommended Dietary Allowances established by the Food and Nutrition Board - National Research Council, adjusted for age, _____ and activity, shall be the nutritional standard used to evaluate meals. Therapeutic diets shall meet these nutritional standards to the extent possible. A summary of the Tenth Edition Recommended Dietary Allowances, interpreted by a daily food guide, is available from the DOEA Assisted Living Program. (b) The recommended dietary allowances shall be met by offering a variety of foods adapted to the food habits, preferences and physical abilities of the residents and prepared by the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the recommended dietary allowances to be made available to each resident	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
---	--	--	-------------------------------

NAME OF PROVIDER OR SUPPLIER MERRIMENT MANOR RETIRMENT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1835 WILSON STREET HOLLYWOOD, FL 33020
---	--

(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 093	Continued From page 9 daily by the facility are as follows: 1. Protein: 6 ounces or 2 or more servings; 2. Vegetables: 3 5 servings; 3. Fruit: 2 4 or more servings; 4. Bread and starches: 6 11 or more servings; 5. Milk or milk equivalent: 2 servings; 6. Fats, oils, and sweets: use sparingly; and 7. Water. (c) All regular and therapeutic menus to be used by the facility shall be reviewed annually by a registered dietitian, licensed dietitian/nutritionist, or by a dietetic technician supervised by a registered dietitian or licensed dietitian/nutritionist, to ensure the meals are commensurate with the nutritional standards established in this rule. Portion sizes shall be indicated on the menus or on a separate sheet. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. This review shall be documented in the facility files and include the signature of the reviewer, registration or license number, and date reviewed. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus to be served shall be dated and planned at least one week in advance for both regular and therapeutic diets. Residents shall be encouraged to participate in menu planning. Planned menus shall be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, shall be kept on file in the facility for 6 months. (e) Therapeutic diets shall be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MERRIMENT MANOR RETIRMENT HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1835 WILSON STREET HOLLYWOOD, FL 33020		
(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 093	Continued From page 10 or family style dining are not required to document what is eaten unless a health care provider 's order indicates that such monitoring is necessary. However, the food items which enable residents to comply with the therapeutic diet shall be identified on the menus developed for use in the facility. 2. The facility shall document a resident 's refusal to comply with a therapeutic diet and notification to the resident 's health care provider of such refusal. If a resident refuses to follow a therapeutic diet after the benefits are explained, a signed statement from the resident or the resident 's responsible party refusing the diet is acceptable documentation of a resident 's preferences. In such instances daily documentation is not necessary. (f) For facilities serving three or more meals a day, no more than 14 hours shall elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals shall be evenly distributed throughout the day with not less than two hours nor more than six hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks shall be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food shall be served attractively at safe and palatable temperatures. All residents shall be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, shall be on hand. (h) A 3-day supply of non perishable food, based on the number of weekly meals the facility has contracted with residents to serve, and shall be on hand at all times. The quantity shall be based on the resident census and not on licensed	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MERRIMENT MANOR RETIRMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 WILSON STREET HOLLYWOOD, FL 33020		
(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 093	Continued From page 11 capacity. The supply shall consist of dry or canned foods that do not require refrigeration and shall be kept in sealed containers which are labeled and dated. The food shall be rotated in accordance with shelf life to ensure safety and palatability. Water sufficient for drinking and food preparation shall also be stored, or the facility shall have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to comply with dietary standards. The findings include: a) Review of the menus posted on the bulletin board in the kitchen at 9:45 AM on _____ revealed the current menu for the week was not dated. An interview with the Administrator at 9:50 AM on _____ revealed the the Assistant Administrator was responsible for updating the current menu. It was confirmed that the facility had failed to date the current week's menu prior to serving meals for viewing by the residents. b) An interview with the Administrator at 9:55 AM on _____ revealed the facility does make substitutions at various times to the noted week's menu items. However, it was revealed the facility had not documented any of the substitutions within the last 6 months. c) Observation of the lunch food service revealed	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MERRIMENT MANOR RETIRMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 WILSON STREET HOLLYWOOD, FL 33020		
(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 093	Continued From page 12 the cook and Assistant Administrator failed to measure food items as noted on the menu. An interview was conducted with the Food Service Manager during which he stated that residents are routinely given more food than the menu dictates and they did not think it necessary to follow noted portion sizes. d) Observation of the lunch meal service revealed that the facility did not utilize standardized recipes. An Interview was conducted with the food service manager on _____ at approximately 3:02 PM during which he stated that he made the recipes himself and did not know the recipes had to be standardized.. Class III	A 093			



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Merriment Manor Retirement Home
1835 Wilson Street
Hollywood, FL 33020

RE: CCR #2012012279

Dear Administrator:

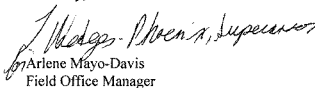
This letter reports the findings of a complaint survey that was conducted on , 2013 by a representative of this office.

Attached is the provider's copy of the State (3020) 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. Staff from this office will conduct a review after 2013 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,


for Arlene Mayo-Davis
Field Office Manager

AMD/lis
Enclosure

