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	AL11910722	11/19/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Lauderhill Manor	2801 Nw 55th Avenue Lauderhill, FL 33313	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - N276 - 58a-5.031(1) Fac - Lns - Nursing Services S-S= D
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= C

Specific Tag Findings:

0000-Initial Comments

An Assisted Living Facility standard, Change Of Ownership (CHOW) with Limited Nursing Services(LNS) and Limited Mental Health (LMH) survey was conducted on Lauderhill Manor, had licensure deficiencies found at the time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC

Based on record review and interview, the facility failed to ensure resident records contain documentation of a completed medical examination recorded on a Resident Health Assessment (AHCA Form 1823) that accurately reflect their current medical diagnoses and care needs, for 1 of 6 residents reviewed (Resident #18)

The findings include:

During an interview with the Med-Tech on at 10:00 AM, it was revealed Resident #18 had a Suprapublic Cathera. Resident #18 was admitted to the facility on Review of Resident #18's Health Assessment dated documents the following diagnosis:

Atherosclerotic History of By-pass Fibrillatin, and Further review of the (AHCA1823 Form) revealed, it did not contain information regarding the presence of a at the time of the survey. It did not indicate

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if he was receiving home health services. Under the section " Service Requirements" was written "none". He was marked as needing supervision for toileting and the comments section was left blank. The medication section was left blank.

An interview was conducted on 11/19 at 11:46 AM, with the Med Tech who was unsure why the 1823 was incomplete and did not reflect the resident's current care needs.

Class III

0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on observation, interview and record review the facility failed to adequately provide care and services appropriate to the needs of the residents. As evidenced by failure to obtain physician orders specifying resident ability to self administer medication and failure to maintain an accurate written record of the residents general health and physical well being, for 1 of 3 sampled residents (Residents #8).

The findings include:

Resident # 8 was admitted to the facility on with a diagnosis to include type 2, and Hyperlipidema. During an interview on at 12:30 PM with Resident #8 he stated he has run out of his medications. He pays for his medications and feels the new owners sent them back to the pharmacy and now want him to pay for the medications to be refilled. The resident stated he spoke with the new Administrator who told him the medications were discontinued. When asked what type of assistance he receives with his medications he stated they fill his pill box and he takes his own medications. The resident pulled his pill box with pills in it out of his pocket. The resident also stated he is an dependant and takes his by himself.

A review on of Resident #8's record revealed a Resident Health Assessment (AHCA1823 Form) dated identifying the resident's need for assistance with medications and home health for and A second (AHCA1823 Form) dated 11/1/13 also identified the resident's need for assistance with medications and home health for

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During an interview on at 1:15 PM with the Administrator and Med Tech, the Administrator revealed she was not aware that Resident #8 was on and did not know if he was assisted with his medications or took them by himself. The Med Tech stated at this time, that the resident takes his by himself and the facility does not monitor him.

During observation on at 1:20 PM with the Med Tech of Resident #8 's the following. The resident has 7 bottles of eye drops in his refrigerator; 3 bottles of Falcon sol 1%, 2 bottles of sol.2% and 2 bottles of sol .25%. A glucometer kit and 1 unidentifiable pill was on the side table. The Med Tech stated, she did not know what the pill was.

A review of Resident #8's 2013 medication observation record (MOR) revealed it did not identify the resident was taking The MOR documented the resident self-administers eye drops. During observation at 1:20 PM on with the Med Tech of the refrigerator in medication , the resident's medications were found and include: filled was not opened orders read three times a day and at bed, sliding scale and flexpen 100 units/m inject 45 units once daily filled all 5 of the flexpens had the tamper proof seals still intact. There was no evidence of documentation the resident has received his since and flexpens since .

On at 9:30 AM, the resident was observed standing at the front door. He stated he was waiting for his ride and that he had an appointment. The resident revealed his pill box to the surveyor, further observations of the box revealed it was filled with medications. During an interview on at 10:25 AM with the Med Tech, she stated the girl on the night shift signed off on the MOR and she fills his pill box at night so he can take his medications during the day. An interview at 10:30 AM with the Administrator to review the MOR, she confirmed the signature on the MOR for was from the girl on the night shift. She stated the resident leaves during the day and they do not fill the pill box they give him the medications and he fills his own pill box.

During an interview on at 11:15 AM with the evening Med Tech, she stated she fills the residents pill box for him at night, so he can take his pills during the day. He takes them at all different times.

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A review of Resident #8 labs dated identified a glucose level of 214 range is 65-99 mg/dl and hemoglobin A1C as 11.9; no additional labs were available for review.

During a telephone interview on at 1:20 PM with Resident #8, he stated he does not write down his glucose levels. He just administers his as needed; 25 units a day and 5-10 units 2 times a day. He checks his glucose levels before breakfast and after lunch. He used to give his prescriptions to the Nurse and now he gives it to the Med Techs. He stated he has been with the same doctor for quite a few years.

During an interview on at 2:40 PM with the night Med Tech, she stated the Nurse would take care of all of the and glucose levels but since the new administration took over they do not have a Nurse and staff does not communicate with the resident regarding his During 2 days of the survey, the facility was unable to provide evidence of documentation regarding monitoring the residents

During an interview on at 2:50 PM with the Administrator regarding Resident #8's medication. The Administrator was taken to the medication refrigerator in the Med shown the residents Levemer pens filled and a bottle of filled both still with the tamper proof seal intact. The order were also reviewed. The Administrator stated she has a problem with the resident because he has so many primary care doctors and takes multiple medications she does not know about his she also stated the facility does not keep track of his glucose levels and she is not aware of his medications.

During a telephone interview on at 3:05 PM with Resident #8's Physician, she stated the resident had been a patient of his for many years, "Quite a few years". She also stated she is the doctor who prescribes all of his medications. The orders were reviewed and confirmed: Levemer pen 35 units sub q in the morning and the pen 5-6 units before each meal if needed. She stated the resident should be keeping track of his levels and that he is on a sliding scale. The doctor went on to say the facility does put his days supplies of pills in a box because he goes out for the day. She stated she did lab work on the resident's A1C level was 7.8 "out of control". The kidney functions are now being watched. She further stated there is nobody at the facility to oversee him since this change

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occurred. I had to give him samples of Levemer and write all new prescriptions because he came to the office on because he said he has had no medicine for 4 days".

After interviewing the resident and his Physician, it was revealed the resident is taking 25 units instead of 35 units as ordered by the doctor. The facility failed to ensure the resident was receiving home health services for his as ordered by the doctor on the health assessment dated 13 and

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS

Based on observation, interview and record review, the facility failed to provide residents with convenient access to a telephone and to honor a residents rights. As evidence of the facility:
1) having residents to go through the facility's receptionist when attempting to make a phone call to dial the number
2) failure to ensure access to adequate and appropriate health care consistent with established and recognized standards within the community, for 1 of 3 sampled resident record reviewed (Resident #12). The facility failed to have Law Enforcement present and utilized for transport during a

The findings include:

1)In an interview conducted on at 10:30 AM with Resident #11 , he stated that in order to make a phone call, you have to give the receptionist the number on a piece of paper and go wait at the resident phone for her to dial the number and then you pick up the receiver to conduct your call. He stated he felt like it was invasion of privacy.

In an interview conducted on at 1:30 PM with Resident #12 , he stated that in order to make a phone call , there is a telephone in the lobby but you have to ask permission to use . The facility is aware of who you are calling at all times because you have to give them the number to dial.

In an interview conducted on at 1:10 PM with the receptionist, she stated that if a resident needs to use the telephone, they bring her the telephone number, she would have to dial it and the resident has to go to the resident telephone located in the lobby and it would ring and they would pick it up to be connected to their party.

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In an interview conducted on at 11:20 AM with Resident #19 , she stated that she has to give the number to the receptionist who dials the number for her and then she has to go to the phone to wait for it to connect to her party.

In an observation made on at 11:25 AM of Resident #19, she was observed going to the receptionist desk, handing the receptionist a piece of paper and going to the resident telephone and waiting for the phone to ring, to conduct her telephone call.

In an observation made on at 1:05 PM of Resident #20, she was observed going to the receptionist desk, handing the receptionist a piece of paper and going to the resident telephone and waiting for the phone to ring to conduct her call.
In an interview conducted on at 2:00 PM with the Administrator, she was unaware that residents were unable to dial out on the resident phone. In an interview conducted on at 2:10 PM with the Activity Director she confirmed that residents are not allowed to dial out , it's because they were dialing 911 all the time.

2)In an interview conducted on at 2:00 PM with Resident #12, he states that on the evening of close to 11:00 PM while he was in bed sleeping, a man who he has never seen, woke him up and told him it is time to go to the hospital, he was with ambulance drivers. He states that the man turned out to be a Clinical Psychologist that the facility had contacted. He further stated that is when they me and took me by non-emergency ambulance to the hospital. He stated that law enforcement was not involved,and did not come to the facility.

In an interview conducted on at 3:31 PM with Staff 7, she stated that she reported to the Psychologist along with other members of the administrative team that Resident #12 had become aggressive and requested an evaluation. She confirmed that she was not present when the evaluation by the psychologist was conducted.

In an interview conducted on at 3:45 PM with Staff 6, he stated he also reported to the Psychologist that Resident #12 had become aggressive. He confirmed that he was not present during the evaluation of Resident #12 by the Psychologist so he was unaware of what had transpired.

In an interview conducted on at 4:00 PM with Staff 4, who was working with Resident #12 on the evening of , she stated that on the resident had been out all day, he was calm and not acting out as she has never had a problem with him. She provided care to him. She states

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that she was very surprised that the resident was . She states he was in bed when the Clinical Psychologist, whom she had never seen before and the paramedics showed up. She did not see Law Enforcement in the building that evening.

In an interview conducted on at 4:15 PM with Staff 5, who was working with Resident #12 on the evening of , she stated that the Clinical Psychologist came in and asked to see resident #12's He went to the the paramedics came. She stated that the resident never demonstrated to have any behaviors and was not exhibiting any behaviors that night. She states that Law Enforcement was not present.

In an interview conducted on at 10:30 AM with the Clinical Psychologist that initiated the , he confirmed that he went to the facility to evaluate the Resident #12, due to the staff reporting to him that the Resident #12 was exhibiting aggressive and combative behaviors. He confirmed that the Resident #12 was on . He confirmed that when he arrived to Resident #12's the resident was in his bed and that he did not observe Resident #12 exhibiting any of the reported behaviors, he was only going by the information reported to him. He stated that he has worked for this company on other occasions and stated that Law Enforcement does not have to be present to transport. He also confirmed that Law Enforcement was not called or present during the , that the resident was transported to the receiving facility via non emergency ambulance.

In an interview conducted on at 11:29 AM with the Administrator, she stated that Resident #12 was creating a hostile environment, being verbally aggressive to staff and other residents. She confirmed that Resident #12 was and Law Enforcement was not involved. She also stated that Law Enforcement does not . She confirmed that she did not file an adverse incident report. During the interview with the Administrator the record was reviewed and she acknowledged that there was no evidence of documentation in the record related to the resident's aggressive behavior to other residents or staff. She also could not provide the names of staff or residents that complained about the resident's behaviors, she did not feel the need to contact Law Enforcement for the transfer of the resident or the adverse incident report.

A review of Resident #12's medical record revealed no progress notes related to aggressive or violent behaviors prior to .

Random residents that resided near Resident #12 interviewed and all stated that Resident #12 was a nice person and had never witnessed any aggressive or violent behaviors.

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0056-Medication - Labeling and Orders 58A-5.0185(7) FAC

Based on observation, interview and record review, the facility failed to follow pharmaceutical guidelines for the administration of medications for 3 of 6 residents reviewed during observation of medication pass, (Resident #1, #2 and #3). The facility also failed to ensure medication was available for Resident #3; and failed to perform medication pass in a sanitary manner for Resident #5.

The findings include:

1) On at 9:20 a.m. medication pass observation for Resident #1 was conducted with the Medication Technician. Review of the Medication Observation Record (MOR) for Resident #1 revealed a physician order for 40 mg medication) daily at 8:00 a.m. with the pharmaceutical direction to Take Daily Before a Meal. An interview was conducted with Resident #1 at 9:22 a.m. who stated she has breakfast at 8:00 a.m. daily.

2) On at 9:35 a.m. medication pass observation for Resident #2 was conducted with the Medication Technician. Review of the MOR for Resident #2 revealed a physician order for 20 mg medication) daily at 8:00 a.m. with the pharmaceutical direction to Take Every Morning Before Breakfast. An interview was conducted with Resident #2 at 9:36 a.m. who stated he had breakfast at 8:00 a.m.

3) On at 9:40 a.m. medication pass observation for Resident #3 was conducted with the Medication Technician. Review of the MOR for Resident #3 revealed a physician order for 40 mg daily at 8:00 a.m. with the pharmaceutical direction to Take Daily Before a Meal. An interview was conducted with Resident #3 at 9:41 a.m. who stated he has breakfast at 8:00 a.m. Further review of the MOR revealed the resident was to receive 4 mg every 12 hours at 8:00 a.m. and 8:00 p.m. During the observation of the medication pass conducted by the Medication Technician, the Medication Technician stated they ran out of last night as the pharmacy only sent a few doses as it is not covered by insurance. She further stated she will have to contact the physician to let him know the medication is not available.

On at 1:45 p.m. an interview was conducted with the Medication Technician who stated she has not contacted Resident #3's physician as yet because she has been very busy. She stated when the facility had a change of ownership on 1st the staffing changed and there used to be 2 Medication Technicians on the day and evening shifts in addition to a nurse on the day shift and as of 1st she is the only Medication Technician on the day shift to assist with medications for the

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70 residents that currently reside in the facility.

On at 3:47 p.m. an interview was conducted with the evening Medication Technician who stated she is responsible for assisting 70 residents with their medications on the evening shift. She stated there used to be 2 techs on evenings but since the change of ownership there is only one tech for the entire facility. She stated it is very difficult for one person to assist all residents with their medications.

4) On at 12:17 p.m. medication pass observation for Resident #5 was conducted with the Medication Technician. The Medication Technician was observed to dispense a pill from the pack however instead of the pill dropping into the medication cup, it dropped onto the paper MOR lying on the medication cart. The Medication Technician was then observed to take a latex glove from a box on the medication cart, pick up the pill with her fingers holding the glove and drop the pill into the medication cup. The potentially contaminated medication was then given to the resident to take instead of being replaced with a medication that had not come in contact with the MOR.

Class III

N276-LNS - Nursing Services 58A-5.031(1) FAC

Based on observation, interview and record review, the facility failed to provide Limited Nursing Services (LNS), for 2 of 2 residents (Resident #13 and #18) observed requiring LNS. As evidenced by lack of assessment and monitoring of an indwelling for Resident #13; and failed to assess and monitor a indwelling for Resident #18.

The findings include:

a) On 11/18 at 9:05 a.m., Resident #13 was observed to be sitting in the main lobby area of the facility when a Home Health Nurse approached the resident and asked him if he emptied his leg bag this morning to which the resident nonverbally nodded in acknowledgement.

On at 9:20 a.m., an interview was conducted with the Assistant Administrator who stated they do not have any residents under LNS at this time.

On at 9:30 a.m., an interview was attempted with Resident #13. However he was not very vocal and stared into space when spoken to. He did, however, state he has lived here for 2 days.

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On at 9:34 a.m., an interview was conducted with the Home Health Nurse who had communicated with Resident #13 in the main lobby who stated the home health agency had just recently received the referral to see Resident #13 to provide tube changes monthly. She stated she has not completed the home health start of care (SOC) initial assessment as yet and anticipates the SOC will be done on Wednesday. The Home Health Nurse confirmed that the agency was not currently assessing the resident's

On at 9:40 a.m., an interview was conducted with the facility day shift Medication Technician who stated Resident #13 has lived in the facility for 2 years and not 2 days as the resident had stated.

Review of Resident #13's record revealed he was admitted to the facility on Review of the last resident assessment (AHCA Form 1823) dated documents the resident's diagnoses to include major and chronic retention with His status is documented as agitated and at times. Review of a physician progress noted dated documents the resident is awake and alert x 2 and continues with chronic retention. The physician documented the indwelling is to be evaluated by the home health agency for monthly changes in lieu of the resident going to the Urologist on a monthly basis.

On at 10:12 a.m., an interview was conducted with the facility Administrator who stated they currently have no residents receiving LNS. A request to review their LNS log was made at this time.

On at 10:18 a.m., observation was made of Resident #13's living quarters. Observation of his no evidence of supplies in plain view.

On at 12:15 p.m., an interview was conducted with the facility Medication Technician who stated Resident #13's is looked after by the home health agency and the facility aides empty the drainage bag. She further stated there used to be a full time nurse on the premises but since the change of ownership on 1st the nurse no longer works here.

On at 12:30 p.m., a second request was made to the Administrator to review their LNS log. The Administrator stated they are still looking for the log and they are not sure where everything is since they just changed ownership on 1st. The Administrator stated they currently do not have anyone on LNS.

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On at 2:00 p.m., a third request was made to the Corporate Assistant for the LNS log who stated they are still looking for it.

On at 2:05 p.m., an additional attempt was made to interview Resident #13. However, he remained nonverbal and walked away when spoken to.

On at 2:47 p.m., a fourth request was made to the Administrator to review their LNS log. The Administrator stated at this time they cannot find the LNS book and reiterated they do not have anyone on LNS at this time. An inquiry was made to the Administrator who is monitoring and assessing Resident #13's and she stated the home health agency nurse is monitoring it. The Administrator was apprised the home health agency has just received the referral to see Resident #13 for monthly changes and the Administrator stated she thought the home health agency had been seeing the resident. The Administrator further stated if Resident #13 needs LNS then she will call in the nurse that they have contracted to do LNS.

On at 3:47 p.m., an interview was conducted with the evening shift Medication Technician who stated she is aware Resident #13 has a and the home health agency is looking after it. She further stated they used to have a nurse on staff but with the new owners there is no longer a nurse who used to 'look after all that kind of stuff.'

b) Resident #18 was admitted to the facility on with a secondary to and . The resident was being followed by a and Home Health Services regarding the since admission. The resident was found during the survey to have a in place. Review of the Resident's last completed, Health Assessment (AHCA 1823 Form), dated , was completed. The 1823 Form did not contain information regarding the presence of a Under the section Service Requirements" was written "none". He was marked as needing supervision for toileting and the comments section was left blank. Physician's orders for the resident could not be found in his medical record, nor provided to the surveyor by staff. Assessment information regarding a LNS nurse could not be found.

An interview was conducted on at 11:46 AM, with the Med Tech who was unsure why the 1823 form was incomplete and did not reflect the resident's current status. The Med Tech attempted to locate the physician's orders and the LNS assessment, but was unable to. The Administrator was made aware. During an interview at 1:15 PM on , the Administrator stated the charts have all been redone with new ownership and the records were in different places in the facility. The Administrator stated she was unaware the resident had a The Administrator validated the facility did not

employ a licensed nurse. An interview on at 12:15 PM with the home health nurse revealed the resident experiences redness to the site frequently. She stated in the past the facility employed a nurse, referring to the nurse as the "Director of Nursing", whom she communicated with. However, under the new ownership she has not been provided a nurse or a name of a nurse to work with in the facility. The resident had a recent change completed at a on and documentation revealed he was administered 1 unit , an , at the appointment.

Class III

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06
Based on record review and interview, the facility failed to obtain a required Level II background screening, for 1 of 5 staff members reviewed.

The findings include:

On , a review of employee records revealed the Assistant Administrator of the facility did not have a Level II background screening completed. This was verified by telephone interview with the Background Screening Unit on at 3:30 PM. An interview with the Assistant Administrator was conducted on at 9:30 AM. He validated he did not have a Level II completed. Further discussion revealed he provides care to the residents on all shifts.

Unclassified

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Lauderhill Manor
2801 NW 55th Avenue
Lauderhill, FL 33313

Re: Change of Ownership (Chow)

Dear Administrator:

This letter reports the findings of a State Licensure Survey that was conducted on , 2013 by a 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. Staff from this office will conduct a review after **2014** 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,

L Wedge-Phoenix, Supervisor

Arlene o - Davis
Field Office Manager

AMD/jw
Enclosure
XG90

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