STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910711	06/19/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Midtown Manor	2001 Polk Street Hollywood, FL 33020	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced licensure complaint survey, CCR# 2014005035, was conducted on [redacted] at Midtown Manor. The facility had deficiencies found at the time of the visit.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on interview and record review, the facility failed to ensure a resident received care and services appropriate to his needs and as physician order, for 1 out of 3 sampled residents (Resident #1). As evidence of the facility failure to maintain documentation of [redacted] monitoring and administration of prescribed [redacted] medication to Resident #1, which resulted in the resident being hospitalized.

The findings include:

Review of Resident #1's Health Assessment (AHCA form 1823) dated [redacted], documented the resident's medical history and diagnoses as Advanced [redacted] and

The physical or sensor limitations noted as unsteady gait. The resident's [redacted] service requirements documented as medication management, safety and comfort measures and [redacted] care.

Review of Resident #1's hospital discharge records revealed a discharge date of [redacted] at 12:48. Hospital instructions noted as follow up with your primary doctor ASAP. Review of the hospital discharge physician orders dated [redacted] revealed an order for [redacted] (300 units/3 ml unit) 15 units to be administered [redacted], before breakfast and dinner. Additionally, an order for [redacted] four times a day, based on a sliding scale after [redacted] glucose testing. The [redacted] dose sliding scale is based on monitored [redacted] glucose levels of the resident throughout the day; the order reads:

[redacted] Glucose Level	[redacted] dose
0-150	0 units of [redacted]
151-200	2 units of [redacted]
201-250	4 units of [redacted]
251-300	6 units of [redacted]
301-350	8 units of [redacted]
351-400	10 units of [redacted]
401 or greater	12 units of [redacted]

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Further review of the hospital discharge records revealed a referral was made for home health services for a RN evaluation, teaching and management. The order notes RN evaluation by home health within 24 to 48 hours.

Review of Resident #1's Medication Observation Record (MOR) for month of 2014, did not reflect the new physician orders (upon readmission to the facility on for the resident or that the resident had received aforementioned medications as prescribed since his readmission to the facility. Furthermore, the record did not reflect any documentation that glucose monitoring had been performed for the resident. During an interview with Med-Tech #1 on at 2:10 PM, she confirmed that the facility had not assisted the resident with aforementioned medications. She also stated she could not recall if the resident's sugar was monitored from to . However, she did confirm that the RN from the home health performed glucose testing on during her visit in the afternoon on .

Review of the Home Health records dated , revealed the following. The Home Health RN made her visit on from 1:15 PM to 2:00 PM (only 1 visit). Further review revealed the resident was prescribed 10 units SQ every evening and daily via sliding scale, with glucose testing results; according to the Home Health notes. Review of the RN evaluation note dated revealed the facility will provide assistance with medical appointments and delivery of medications. The resident is documented as oriented to person and place, able to understand conversations but forgetful. He is dependent, not able to properly administer his own , or use a glucometer for glucose monitoring.

During an interview conducted on at approximately 12:00 PM with Aide #1, she confirmed that she was working at the facility on . Aide #1 stated, she recalls that Resident #1 had gone to dinner around 5 PM and she gave the resident his evening meds (no administered) around 7 PM. She stated the resident's family came to visit and approached her after 7 PM, informing her the resident was sweating profusely and difficult to wake up. She observed the resident, found his clothes were wet and he would not open his eyes; the family called 911. She stated the 911 EMT informed her that the resident's sugar level was 600 at that time and the resident was transferred to the hospital ER for evaluation.

Review of the Hospital ER records dated revealed the resident was assessed to be , weak, nonverbal and a glucose level of 600. He is diagnosed with Hyperosmolar , uncontrolled . He is given a high dose of along with sliding scale as well as fluids. The note documented the resident most likely has noncompliance issue at the ALF and uncontrolled as a result. The resident is described as having history of advanced and type 2 .

During an interview with the Administrator on at approximately 12:45 PM, she confirmed that the facility had not ensured that Resident #1 had received the physician order medications and monitoring. She stated that the facility "dropped the ball" due to lack of communication and they had not contacted the facility's Limited Nursing Service (LNS) nurse to cover the glucose monitoring and administration upon readmission of Resident#1 on . She confirmed the facility's LNS license was current and that the facility could have provided nursing services to the resident, including and glucose monitoring. She also acknowledged

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the resident had prior admissions to the facility and the care staff should have been familiar with his needs.

The facility failure to provide and/or arrange for the administration of physician order medications to Resident #1 directly threatened the physical and emotional health of the resident. As evidence of Resident #1 requiring acute care on . . . . . due to high glucose levels.

Class II

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation and interview, the facility failed to provide a safe and sanitary living environment.

The findings include:

A) An observation tour was conducted between 9:30 and 11:30 AM on . . . . . Observations and interviews were conducted during this tour focusing on allegations of failure to provide a clean environment. The facility staff which consisted of home health aides was observed completing various duties of direct care. No housekeeping staff was observed during the entire survey process. Interviews conducted with random alert residents and staff revealed a recent change had occurred in housekeeping services. The facility is commencing with a large renovation project which contributes to dust accumulation throughout the building.

Concerns /Observations made during the tour are:

1. Observed signage on numerous facility entrance doors indicating "renovation within the facility". (see photo evidence) Several painters were observed painting chair rails along the main entrance hallway. Numerous residents were observed with white paint on their arms and clothing. Large blue tape "X"s were noted along the floor, near the base boards. No "wet paint signs" were noted throughout the facility.(See photo evidence)

2. Observation of the main elevator, near the front door, the floor was dusty and trash/papers were mixed with construction dust.

3. Observations were made of resident . . . . . during the tour:

. . . . . an aide was observed mopping the floor with strong smelling , no residents were observed in the . . . . . the time

. . . . . observation of dirty toilet bowl, rust on the shower floor

. . . . -the floor was dusty

. . . . . the floor was dirty and dusty

. . . . . the floor was soiled/ dusty

. . . . . a strong smell of . . . was noted upon entrance, 4 beds were noted in the . . . . . 2 residents were present, one resident was eating her breakfast and the other was sleeping.

. . . . . grout was missing and soiled

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the shower stall was stained and dirty, grout was missing from around the toilet bowl

the vacant, all the wall boards had been removed exposing bare pipes and electrical wiring. Piles of dirt, dust and construction debris was noted on the floor. to be unlocked and unsupervised.

the was soiled/dirty

the floor was dirty

During an interview conducted with Resident # 4 on at approximately 9:00 AM, she stated that she had experienced a decrease in housekeeping services, which resulted in her dusty, the floors were dirty and her not cleaned. She stated that the housekeeping staff had cleaned her and now the care staff/aides clean once a week. She could not recall when her bed linens were last changed. During an another interview conducted with Resident #5 on at approximately 9:15 AM, she stated that since the housekeeping staff had been let go, her dirty, the floor had not been mopped and the was not properly cleaned.

On at approximately 9:30 AM confidential interviews were conducted with several aides. They stated that the housekeeping staff had been terminated and now the responsibilities/duties on the aides to clean the facility, as well as provide resident care. They stated that the residents and families are not happy with the decision.

An interview was conducted with the Administrator on at 10:30 AM, she stated that 5 housekeeper positions had been eliminated. Currently there was no housekeeping staff at the facility. The resident care aides now are required to empty trash, sweep make resident beds daily, along with caring for the residents ADL needs. The are cleaned weekly and bed linens are changed on Monday. She stated that she was aware that families and residents had been complaining about the decrease in housekeeping services. She acknowledged that there is an increase in dust and dirt with the renovation/construction. She stated that the facility meets the minimum staffing hours. She could not provide a cleaning schedule for resident

Review of Facility "Contract for Care" revealed the statement, "for the monthly fee, the facility agrees to provide and make available the following basic services including: well- maintained housekeeping services, and medication management.

B) An interview was conducted on at approximately 12:30 PM with the Administrator. She confirmed that Resident #1 was admitted to the facility on and with a physician order for ambulating with a walker. She confirmed that the walker has been delivered the same day, but the facility has not been able to locate it. She stated that the resident had numerous admissions and had never received the walker. The Administrator was unable to provide any evidence that the facility replaced the missing walker and/or resolved this grievance.

Class III

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0054-Medication - Records 58A-5.0185(5) FAC
Based on observation, interview and record review, the facility failed to maintain an accurate daily medication observation record (MOR) for a resident. As evidenced by facility failure to accurately document medications prescribed by the physician on the MOR, for 1 of 3 sampled residents (Resident #1).

The findings include:

Record review for Resident #1 revealed the resident was readmitted to the facility from the hospital on [redacted]. The resident has a medical history of [redacted] with labile [redacted] glucose level control. Review of the hospital discharge physician orders dated [redacted] revealed an order for [redacted] (300 units/3 ml unit) 15 units to be administered [redacted] before breakfast and dinner. Additionally, an order for [redacted] four times a day, based on a sliding scale after [redacted] glucose testing, was also reviewed. The [redacted] dose sliding scale is based on monitored [redacted] glucose levels of the resident throughout the day. The order reads:

Glucose Level	dose
0-150	0 units of [redacted]
151-200	2 units of [redacted]
201-250	4 units of [redacted]
251-300	6 units of [redacted]
301-350	8 units of [redacted]
351- 400	10 units of [redacted]
401 or greater	12 units of [redacted]

Review of the [redacted] 2014 Medication Observation Record (MOR) did not reflect the physician admission orders for the resident or that he had received these medications as prescribed since his admission. Furthermore, the record did not reflect any documentation that [redacted] glucose monitoring had been performed for the resident.

On [redacted] at approximately 12:00 PM during an interview with the Administrator, she stated the resident had not received his medications as prescribed. She confirmed that when medications are prescribed by the physician, the MOR should be documented accurately to reflect the orders and the medications should be administered as ordered.

Class III

0165-Risk Mgmt & QA; Adverse Incident Report 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC
Based on record review and interview, it was determined the facility failed to complete and submit an adverse incident report (initial adverse incident report/1 day report) regarding an event in which a resident required the transfer from the facility to a unit providing more acute care, for 1 out of 3 sampled residents (Resident #1).

The findings include:

During an interview conducted on [redacted] at approximately 12:00 PM with Aide #1, she confirmed that she was working at the facility on [redacted] Aide #1 stated, she recalls the Resident #1 had gone to dinner around 5 PM and she gave the resident his evening meds around 7 PM. She stated the resident's family came to visit and approached her after 7 PM, informing her the resident was sweating profusely and difficult to wake up. She observed the resident, found his clothes were wet and he would not open his eyes; the family called 911. She

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stated the 911 EMT informed her that the resident's sugar level was 600 at that time and the resident was transferred to the hospital ER for evaluation.

Review of the Hospital ER record dated revealed the following. The resident was assessed to be weak, nonverbal and have a glucose level of 600. He is diagnosed with Hyperosmolar uncontrolled He is given a high dose of along with sliding scale as well as fluids. The note documented the resident most likely has noncompliance issue at the ALF and uncontrolled as a result. The resident is described as having history of advanced and type 2

During an interview with the Administrator at 1 PM on , she stated that the facility had not completed and submitted an adverse incident report regarding aforementioned incident. She also stated that facility had no documentation regarding aforementioned incident and that the facility had not investigated the incident to prevent further occurrence.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Midtown Manor
2001 Polk Street
Hollywood, FL 33020

RE: CCR #201405035

Dear Administrator:

This letter reports the findings of a complaint inspection survey conducted on 2014, by representatives of the Agency for Health Care Administration (AHCA). Attached is the provider's copy of the State (5000-3547) Form, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days of receipt of this report**.

The inspection resulted in findings of non-compliance in the following areas:

A - 0025 - 58A-5.0182(1) FAC - Resident Care – Supervision – Scope & Severity = G
A - 0030 - 58A-5.0182(6) FAC; 429.28 FSs-Resident Care-Rights & Facility Procedures, Scope & Severity = D
A - 0054 - 58A-5.0185(5) FAC - Medication – Records, Scope & Severity = D
A - 0165 - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC - Risk Mgmt & QA; Adverse Incident Report, S-S= D

Directed Corrective Actions:

1. The Assisted Living Facility is required to establish a policy and procedure for monitoring all care needs for residents with a diagnosis of or related diagnosis. The policy should include a log for all residents requiring administration of medications. This log should contain information regarding who will be responsible for providing the nursing service (ie. Home Health or the ALF nurse or the Resident), type of services provided (ie. sugar testing; administration; or oral medication) and the frequency of the service (ie. Twice a day, Daily, Weekly,etc). This log must be updated immediately upon changes in service provider. The facility should identify the person responsible for implementing and monitoring the policy.

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com

2. The Assisted Living Facility is required to establish a policy for evaluating a resident upon readmission to the facility after hospital discharge. This policy must include steps and procedures for the facility to ensure a resident's needs are met and provided upon readmission from the hospital. This policy should identify the person responsible for implementing and monitoring the policy.

3. The Assisted Living Facility is required to establish a policy and procedure for ensuring changes and/or new medication orders are transcribed to the Medication Observation Records timely. This policy should define "timely" and identify the person responsible for implementing and monitoring the policy.

4. The Assisted Living Facility is required to review its Limited Nursing Services policies and ensure that the facility nurse performs services as needed.

5. The Assisted Living Facility is required to establish a policy and procedure for evaluating significant changes and updating facility records and a resident's record accordingly. This policy should identify the person responsible for implementing and monitoring the policy. The facility must complete and submit an adverse incident report regarding the incident that occurred on in which Resident #1 was transferred to an acute facility.

6. The Assisted Living Facility is required to ensure that the facility is maintained in a safe and sanitary manner at all times. The facility must establish policy and procedures to ensure residents' safety during renovations. This policy should identify the person responsible for implementing and monitoring the policy.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call Tikel Wedges-Phoenix, Health Facility Evaluator Supervisor at 561-381-5846 and Kimberly Smoak, Survey and Certification Support Branch, at (850) 412-4505.

Sincerely,

T. Wedges - Phoenix, Supervisor

Arlene Mayo-Davis
Field Office Manager

AMD/dmb