STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910722	07/07/2014
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 - 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 - 0053 - 58a-5.0185(4) Fac - Medication - Administration S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced licensure complaint survey, CCR#2014003784, #2014003502, #2014004251 & 2014003764, was conducted on . . . . . at Lauderhill manor. The facility had deficiencies found at the time of the visit.

Deficient practice was identified at:
CCR#2014003764 at A 0025 and A 0152
CCR#2014003502 at A 0162
CCR#2014003784 and 2014004251 at A 0052 and A 0053

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on record review and interview, the facility failed to ensure as part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a health care provider as specified in either paragraph (a) or (b) of this subsection or completed after the resident's admission to the facility within 30 days, for 2 of 4 residents reviewed. (Resident #1 & #2)

The findings include:

Resident #1 was admitted to the facility on . . A review of the AHCA form 1823 dated has a diagnosis to include chronic . . . and . Page 2 section D of the form is blank and does not identify if the individuals needs can be met in an assisted living facility which is not a medical nursing or . . facility. page 4 section B notes the resident need help taking his medications but does not identify medication administration or assistance with self administration.

Resident #2 was readmitted to the facility on . . . . . A review of the AHCA form 1823 dated . . has a diagnosis to include . . . . . of right . . . Page 4 section B is blank and does not document if the resident needs help taking his medications or identify medication administration or assistance with self administration.

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During an interview with the Administrator on at 1:00 PM, he acknowledged the findings.

Class III

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

Based on observation, interviews and record review, the facility failed to provide care and services appropriate to the needs of residents accepted for admission to the facility. As evidenced by not maintaining a written record, update as needed any significant changes that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services: observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident, for 3 of 4 sampled residents (Resident #2, #3, #4 & #6).

The findings include:

1) Resident #4 was admitted to the facility on and readmitted to the facility on . A review of the AHCA form 1823 dated has a diagnosis to include , ostomy and . The resident is total assist with transfers, dressing and toileting. Page 4 section B does not identify if the individual needs help taking med's and what type of assistance.

During an interview on at 1:00 PM with Resident #4, he stated he returned from the hospital on and the facility still does not have all of his medications. He stated he has asked for help multiple times in the past and staff " flat out says NO. He stated he and shattered his knee on , he was yelling for help but nobody came until his service dog started barking. They found him on the floor picked him up and put him back in bed.

A review of the medical record revealed a note dated 12pm " resident had a on 11pm-7am shift left leg very and in pain transfer via amr." Resident was hospitalized until , when he returned to the facility.

During an interview on at 11:15 AM with the med tech, she stated med techs complete the incident reports. The incident log was requested and did not document the residents

During an interview on at 11:20 AM with the Administrator and Assistant Administrator regarding Resident #4's and to review the incident log. The facility was not able to locate the incident report and the assistant administrator stated "the med tech took the incident report home." The

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med tech was immediately contacted in the presence of the Assistant Administrator at 11:40 AM and during the telephone interview the med tech stated she "came in the morning and found him in bed with an ice pack on his leg and it was very so I called 911 and sent him out because he was complaining of pain". The med tech stated she found the resident in bed the following day and she did not know what happened or complete any incident report. It was unable to be determined how long the resident layed on the floor before staff came to assist. The resident was put back into bed and left in pain with a leg prior to being found the following day.

During an interview on at 12:00 PM with the Administrator and Assistant Administrator regarding Resident #4's they did not know who found the resident or what happened. The staffing schedule was reviewed for the month of They were unable to determine what staff member was assigned to the residents the evening shift and who put the resident back in bed with a leg and ice pack, complaining of pain without documenting the , assessing the resident or completing an incident report for an injury resulting in a that required transfer to the hospital.

2) A request was made on at 10:00 AM to the Administrator and Assistant Administrator for Resident #2 ' s record. During an interview at 3:30 PM with the Administrator and Assistant Administrator, the Assistant stated she was not able to locate the resident ' s record and did not have any information regarding the resident. On at 11:40 AM, the Administrator provided a folder that included the residents demographic sheet, an initial admission note dated and a resident observation log dated "PM" that identifies the new admission " Resident brought bottles of medications upon admission. " The residents medication observation record (MOR) was requested. During the 2 days of survey the facility was not able to provide evidence of documentation of a MOR that the resident received any of his medications for the 8 days he resided at the facility or a copy of his financial contract.

During an interview on at 1:00 PM with the Administrator and Assistant Administrator, they both stated the facility did not have any additional documentation regarding Resident #2.

3) During an interview on at 12:30 PM with a resident who wishes to remain anonymous it was stated the facility has had no working call system for over 3 months. The resident stated they know when they need to go to has "no way to call, we have to go to the front desk and ask them to call a certified nurse assistant (CNA). The CNA's are not always available. I sit wet because its so hard to find someone to help. During the night nobody is around I have had to stay wet thru the night because after certain hours nobody answers the phone if we call, nobody wants to help , they don ' t seem to care, no sense of commitment. " During the interview the resident was observed in a wheelchair with hand contractors.

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4) At 12:35 PM, a Resident #6 was observed walking with a feces soiled diaper in his hands down the hallway went into the lobby when asked if he was ok he stated he threw it away. The resident stated, he did not know his name and was identified by a staff member who observed the incident.

5) On at 10:10 AM, a tour of the facility was conducted to assess the status of the physical plant. While walking by section I of the facility, a strong odor was noted in the vicinity of Thereafter, Resident #3 was observed in tears sitting at the portico of her sorting through her cleaning and hygienic products. After a brief introduction, she quickly informed that she was in tears because "someone told me that I stink". She was asked whether she knew the person who made that statement, she replied no, but it was a man. She said that she had three and was unable to care for herself. She pointed out that she has a lot of cleaning products for her hygiene. But, she depends on staff to address her cleanliness issues.

She continued and said that someone changed her the morning of at about 6:00 AM or 7:00 AM. But, she's been very often lately. Meanwhile, a very strong odor was still present, both next to the resident and in her

The Administrator presence was requested, so that he could address the resident's issue. Although he acknowledged the strong odor and was informed by the resident that someone told her she "stunk", he did nothing. The Administrator, standing outside the resident's , he said that he did not have any male staff working at this time. Therefore, it was not one of his staff members who made the statement and then he walked off without making any effort to address the resident's psychosocial disturbance caused by the offense, nor the resident's immediate need for care. After talking to the resident, he went to his office, ignoring the situation.

At 10:30 AM, the housekeeper, assigned to section 100 who also was stationed next to the resident's was observed entering the resident's made a voluntary effort to the After a while, by 11:00 AM, it was noted that the effect faded and the odor resurfaced or was still present in the The resident sat in her the overbearing smell. At 11:14 AM, another surveyor was called in to assess the situation. It was at that time determined the resident's pant was soiled and no one had changed.

At 12:17 PM, the resident was wheeled by the Receptionist to the dining lunch while wearing the same soiled blue jeans. She left the dining by approximately 1:20 PM. She was taken to her

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and stayed there with the same soiled clothes till around 2:45 PM. At 2:50 PM, the resident was observed seating in her wheelchair dozing off wearing this time a black "sweat pant". After questioning her, she answered that she was changed a few minutes ago.

During a conversation with the med tech on at 11:16 AM, she indicated that there is one Certified Nursing Assistant for section 100 during the day, and it's difficult for her to address the needs of all the residents. She said that she is aware of the resident's strong odor and had encouraged the resident to drink a lot of fluid. However, the resident informed her that she is afraid to drink for fear of wetting herself.

During an interview with the Assistant Administrator on at 11:45 AM, she reported that Section 100 has 44 residents. Review of the Residents' Condition Roster on revealed that there are 53 residents who are in the facility and 44 of them reside in section 100 of the facility.

Review of Resident #3's Health Assessment (AHCA form 1823) revealed that she suffers from and has a history of Aneurysm with Further review of the records indicated that she is and oriented person, time and place, she requires assistance on and off toilet, and needs assistance with all her activities of daily living.

Record review of Residents Observation Log on revealed that Resident #3 on Subsequent to that , a plan was devised to have the resident toileted after each meal. Meanwhile, after lunch on the resident was neither toileted nor changed.

6) During an interview with a staff member who wanted to remain anonymous regarding answering resident calls they stated the phone goes out of range at the end of the hallways. A phone was taken with the facility employee in resident hallways between -222 and the phone display documented "out of range"

During random resident interviews on with residents who wished to remain anonymous it was confirmed that the staff do not answer the phone after certain hours which is approximate after 5:30 PM. The residents stated they wait a long time and it is very difficult to find anyone to help when they try to call for assistance.

During interview with facility employees on regarding how residents call for assistance, they stated they have no way of communicating with the residents unless they walk up to the front desk or the girl at the desk tells them to go see a resident. The facility staff also stated they can not get to all of the

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residents and the residents complain that it takes to long to get help. In some cases the facility employees stated they feel bad and have given their personal cell numbers to the residents. The facility employees wished to remain anonymous.

During an interview on at 2:20 PM with the Administrator, he stated the employees do not carry a phone or radio during their shifts. At night 1 person in the facility has a portable phone for a census of 88. If an incident occurs the aide would have to leave the area to get someone to help. He also stated he was not aware the phones go out of range at the end of the hallways.

Class III

0053-Medication - Administration 58A-5.0185(4) FAC

Based on record review and interview, the faciltiy failed to administer medications in accordance with a health care provider's order or prescription label, for 1 out of 1 sampled residents (Resident #4).

The fidnings incloude:

Resident #4 was admitted to the facility on and readmitted to the facility on . A review of the AHCA form 1823 dated has a diagnosis to include , ostomy and . The resident is total assist with transfers, dressing and toileting. Page 4 section B does not identify if the individual needs help taking med's and what type of assistance.

During an interview on at 2:00 PM with the medication tech to reconcile resident #4's medications, the 2014 MOR was reviewed and the following was revealed: Atenol 25mg 1 8 am & PM facility only had the morning dose, 20 mg 1qd not signed off 7/3-7/1 , 5 mg 1qd not signed off 7/3-7/7, 5 mg not signed off 7/1-7/8, 20 mg not signed off 7/3-7/7, Oscal 500 mg 1 qd not signed off 7/3-7/7, 10 meq 1 qd not signed off 7/3-7/7.

During medication reconciliation on at 2:00 PM the med teach stated the facility still does not have the following medications: 10 mg 1 hs, 1 hs, Cranberry concentrate 500 mg 1 and Vistril 50 mg 1 hs prn The med tech could not provide evidence the resident received the above listed medications as ordered by the physician and did not know why the facility failed to have physician ordered medications available for the resident. There was no evidence of documentation the facility tried to contact the pharmacy about the medications or notify the resident ' s physician that he was not receiving his medications as ordered.

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Class III

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC
Based on observation and interview, the assisted living facility failed to ensure that all walls, tiles, ceiling and carpet in areas designated for resident use were clean, in good repair and provided a safe living environment.

The findings Include:

a) Observations on at approximately 10:00 AM, found the carpeted area in the lobby where many residents congregate, was heavily stained. Further observations found that many tiles at the entrance of section 200 from the lobby were broken and needed to be replaced.

b) Observation on at approximately 1:40 PM, found the the hallway of Section 200 which is used by the residents when they are either in the lobby of in the entertainment hall, had peeling paints, and wall plastering that have not been repainted.

c) While touring the facility in the morning of many areas of the ceiling in different area of the building were observed to be stained suggesting leakage of the roof. In section 200 multiple plastic containers were observed in an area where the ceiling was caving in and was heavily soaked.

In an interview with multiple residents throughout the survey, they indicated that the tiles at the main entrance have been that way for a while and could be repaired.
During an interview with the Maintenance Director, he reported that they were in the process of making repairs to the facility and the leakage observed was caused by the Air Conditioning unit which will be either changed or repaired.

In an interview with the Administrator on at approximately 11:30 AM, he stated the tiles in the lobby are marble tiles and have been mistreated over the years and consequently have lost their original texture and shines. He also stated that the building was being repaired and renovated. However, he reported that he did not have a work order for the repairs being done or regarding aforementioned issues noted

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0162-Records - Resident 58A-5.024(3) FAC

Based on interview, the facility failed to ensure all resident records must be retained for 2 years following the departure of a resident from the facility, for 1 of 1 sampled residents (Resident #2)

The findings include:

A request was made on at 10:00 AM to the Administrator and Assistant Administrator for Resident #2 ' s record. During an interview at 3:30 PM with the Administrator and Assistant Administrator, the Assistant stated she was not able to locate the resident ' s record and did not have any information regarding the resident. On at 11:40 AM the Administrator provided the residents demographic sheet and an initial admission note dated . . . . The resident observation log dated PM identifies the new admission " Resident brought bottles of medications upon admission. " Second note dated . . . . documents the resident ' s family member removed him from the facility. The residents medication observation record (MOR) was requested. During the 2 days of survey the facility was not able to provide evidence of documentation of a MOR or that the resident received any of his medications for the 8 days he resided at the facility or his financial contract.

During an interview on at 1:00 PM with the Administrator and Assistant Administrator, they both stated the facility did not have any additional documentation regarding Resident #2.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

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

RE: CCR #2014003784, CCR #2014003502, CCR #2014004251 & CCR #2014003764

Dear Administrator:

This letter reports the findings of complaint surveys that were conducted on , 2014 and , 2014 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after 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,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

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