STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910711	08/19/2014
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List of Tags Cited:
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0026 - 58a-5.0182(2) Fac - Resident Care - Social & Leisure Activities S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0079 - 58a-5.019(3) Fac - Staffing Standards - Levels S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0082 - 58a-5.0191(3) Fac - Training - S-S= D
St - A - 0090 - 58a-5.0191(11) Fac - Training - S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0161 - 58a-5.024(2) Fac - Records - Staff S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D
St - A - L241 - 58a-5.029(2) Fac - Lmh - Records S-S= D
St - A - N278 - 58a-5.031(3) Fac - Lns - Records S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced Change of Ownership (CHOW) survey with Limited Mental Health (LMH) and Limited Nursing Services (LNS) was conducted on through at Midtown Manor. The facility had licensure deficiencies found at the time of the visit.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on interview and record review, the facility failed to ensure Resident Health Assessments (AHCA Form 1823) reflected changes in condition, for 3 of 8 resident records reviewed (Residents' #9, #10, and #12). As evidenced by the 1823 Health Assessments not being updated to reflect admission to hospice care.

The findings include:
1) Resident #9 was admitted to the facility on with a diagnosis of accident. Review of Resident #9's record revealed he was placed under hospice care on . Further review of the record revealed the last 1823 Health Assessment is dated . There is no evidence in the resident's record of an updated 1823 to reflect the change in condition that warranted admission to hospice care.

2) Resident #10 was admitted to the facility on with a diagnosis of . Review of Resident #10's record revealed she was placed under hospice care on . Further review of the record revealed the last 1823 Health Assessment is dated with no evidence of documentation the resident was admitted under hospice care 2 months prior or the change in condition that warranted

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admission to hospice care.

3. Resident #12 was observed in a recliner on at 9:05 a.m. She said she does not walk. The resident's 1823 Health Assessment was reviewed and documented that the resident was independent with ambulation. In addition, there was a note in the resident's chart for of 2014 documenting that she is receiving hospice services, and this was also observed during the survey. There was no mention of hospice services on the resident's most recent health assessment. An interview was conducted with aide "A" on at 10:35 a.m. and she verified the resident is on hospice and no longer walking and agreed the Health Assessment needs updating.

On at approximately 1:00 PM, an interview was conducted with the Administrator who confirmed a new 1823 Health Assessment should be done if a resident's status changes and being admitted under hospice is a change in condition.

Class III

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

Based on interview and record review, the facility failed to ensure resident records accurately reflected their condition for 3 of 8 residents (Residents' #5, #9, and #15) sampled for record review. As evidenced of the facility failing to document the status of the residents prior to transfer to the hospital and on readmission to the facility for Resident #5 and Resident #9, failing to document the status of a for Resident #9, and failing to document Resident #15's transfer to another facility and readmission.

The findings include:

1) Resident #5 was admitted to the facility on with a diagnosis of and insufficiency. Review of the resident's record revealed documentation from the hospital indicating the resident was admitted to the hospital on and discharged from the hospital on . Review of the documentation from the hospital did not have any diagnosis listed for the hospital admission.

Review of the Resident Observation Log revealed an entry dated with the next entry dated with no evidence of documentation for the reason the resident was admitted to the hospital on in addition no evidence of documentation of the condition of the resident upon return to the facility on .

On at approximately 1:30 PM, an interview was conducted with staff member 'A' who after review of the record was unable to state or find the reason the resident was admitted to the hospital or what his condition was upon return to the facility.

2) Resident #9 was admitted to the facility on with a diagnosis of accident.

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Review of the Resident Observation Log revealed an entry dated that the resident passed out and was purple, 911 was called and he was transferred to the hospital. The next entry in the Resident Observation Log is dated with no evidence of documentation of when the resident was readmitted to the facility from the hospital or the condition of the resident upon return.

Further review of the record revealed hospital documentation for discharge instructions for a diagnosis of dated

Additional review of the record revealed hospice agency notes documenting the resident was admitted to hospice care on which would indicate the resident was either discharged from the hospital on or Additionally, further review of the resident's record does not have any evidence of documentation regarding the resident's decline in condition that would warrant admission to hospice care.

On at approximately 1:35 PM, an interview was conducted with staff member 'A' who after review of the record was unable to determine when the resident returned from the hospital nor what his condition was to warrant hospice care.

On at 11:20 AM, an interview was conducted with the Hospice Registered Nurse who stated he is in the facility daily seeing residents and visits with Resident #9 three times a week. He further stated Resident #9 has a healing to his sacral area which he assess at every visit. Review of the resident's record revealed no evidence of documentation of a when it started and the current status of it. On at 1:20 p.m. an interview was conducted with staff member 'A' who stated she is not a nurse so she cannot assess a She further stated the hospice nurse would document on his notes but she is not sure if anyone in the facility would document about the in their records.

The facility is licensed for Limited Nursing Services (LNS). The list of residents provided by the facility on the first day of the survey identified as receiving LNS was reviewed and Resident #9 is not listed as receiving any services.

On at 1:45 PM, an interview was conducted with the Administrator who stated she cannot explain why there are no notes in the chart for these 2 residents.

3) During an interview with Resident #15 on at 2:00PM, he referred to an admission this year at another assisted living facility. The resident's record was reviewed. The resident was admitted to the facility on , and there were no notes referencing a discharge or readmission to the current facility.

On at 3:30 PM, the Administrator was interviewed. She stated that the resident was temporarily relocated to another assisted living facility earlier this year while his being

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renovated and she thought she had noted it. No further documentation was provided.

Class III

0026-Resident Care - Social & Leisure Activities 58A-5.0182(2) FAC
Based on observations, record reviews and interviews, the facility failed to provide an ongoing activities program that included scheduled activities at least 6 days a week for not less than 12 hours.

The findings are:

On during interviews with several residents, they reported that the activities do not meet their interests and all there was to do was Bingo three times a week and happy hour on Friday. During observations on at 9:45 a.m. it was noted that the activity calendar listed exercise from 9:30 a.m. to 10:00 a.m. A tour was conducted of the main floor including the dining , TV outside patio and no exercise activity was taking place. On the calendar from 1:30 p.m. on there was "Movie" listed. A tour of the TV , dining outside patio revealed no movie showing.

The staff schedule was reviewed and on a daily basis from 2:00 until 4:00 there was an aide assigned to "activities", which did not correspond to the times on the activity calendar.

The facility contract was reviewed and documented that the facility would offer activities three hours a day, five days a week, not per the regulations.
The administrator was interviewed on at 3:30 p.m. and no additional information was provided.

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 ensure the residents' right to a safe and decent living environment for the residents receiving medications (medication pass was not performed in a sanitary manner to prevent potential for cross contamination by Medication Technicians 'A' and 'D'); failed to ensure residents who were dining were assisted and allowed ample time to complete their meal; failed to ensure that bed side-rails were only used when ordered by the health care provider (Resident #12); and failed to ensure that residents were treated with respect and dignity for the residents during dining and activities (Residents' #18, #11 and #12).

The findings include:

1) On at 11:45 a.m. a medication pass observation was conducted with Medication Technician (med tech) 'D' for Resident #13. The med tech was observed to don a pair of gloves, flip through the Medication Observation Record (MOR), open the medication cart and retrieve the

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resident's medications. The med tech brought the medication to the resident and after the resident took her medications the med tech patted the resident on her shoulder. The med tech then proceeded back to the medication cart and going through the MORs and the medication cart retrieved the medication for Resident #14. She proceeded to go to the resident and after the resident took his medication she went back to the medication cart and doing the same process flipped through the MORs and retrieved medications for additional residents wearing the same gloves she donned at 11:45 a.m.

At 12:04 p.m. med tech 'D' was observed to walk out of the dining the same gloves on to assist a resident, steadying the resident by putting her hands on the resident's shoulders. She then proceeded back into the dining the same gloves on and continued with medication pass for other residents. At 12:10 p.m. med tech 'D' was observed to remove the gloves she donned at 11:45 a.m. and without washing or sanitizing her hands she donned a new pair of gloves. At 12:16 p.m. med tech 'D' was observed to be mingling among the residents sitting at the tables, touching the resident's shoulders and touching backs of chairs wearing the gloves she donned at 12:10 p.m.
At 12:25 p.m. med tech 'D' was observed assisting a resident with his meal and she then proceeded to use the phone in the dining the gloves she donned at 12:10 p.m.

At 12:28 p.m. med tech 'D' was advised by a resident that was exiting the dining there was water on the floor next to a resident seated at a table close to the entrance door. Med tech 'D' was observed to pick up and place a chair over the water on the floor next to the resident and then proceeded out of the dining returned with a 'wet floor' sign and placed it next to the spill. Med tech 'D' continued to have the same gloves on she donned at 12:10 p.m. At 12:30 p.m. med tech 'D' was observed to exit the dining go to a housekeeping closet to retrieve a mop. She returned to the dining , mopped up the spill, put the mop in a storage closet next to the kitchen and returned to her medication cart to continue with medication pass. Her subsequent medication passes were done with the gloves she donned at 12:10 p.m.

2) On at 11:55 a.m. a second medication pass observation was conducted with med tech 'A' in addition to observing med tech 'D' perform her duties. Med tech 'A' was observed to flip through the MORs and retrieve the medication for Resident #15. After the resident took his medication med tech 'A' returned to the medication cart, flipped through the MOR and retrieved the medication for Resident #16. After the resident took her medication the med tech returned to the medication cart, flipped through the MOR and retrieved the medication for Resident #17. The medication pass observation with med tech 'A' for these 3 residents commenced at 11:55 a.m. and ended at 12:03 p.m. At no point during the medication pass observation did med tech 'A' wash or sanitize her hands between residents. While observing med tech 'D', med tech 'A' was also being observed at the same time and she continued to pass medications to other residents in the dining by one without washing or sanitizing her hands inbetween residents or after touching residents or chairs.

On at approximately 1:00 p.m. the Administrator was apprised of the observations. The Administrator had no comment.

Review of the facility policy for handwashing states in part, 'Hand washing is the single most important

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means of preventing the spread of [illegible] in the health care facility. Employees hands must be washed before and after direct care of individual residents and during performance of normal duties to preparing or serving meals, drinks, etc.'

3) On [illegible] at 10:00 a.m. during the initial facility tour with the Administrator the dining [illegible] observed. The Administrator stated the first shift lunch begins at 11:30 a.m. for those residents who require assistance and the second shift lunch from 12:00 p.m. to 12:45 p.m. is for those residents who are independent.

On [illegible] at 12:00 p.m. residents from the first shift lunch were observed still in the dining [illegible], some of which were still eating. It was noted there were only 2 aides assisting in the dining [illegible] one handed out meal trays and the other was walking around with a coffee pot.

On [illegible] at 12:02 p.m. observation was made of residents on the second shift piling into the dining [illegible] going straight to the tables that they usually eat at. It was observed the dishes from the first shift had not been cleared yet and residents from the second shift were sitting at tables with the dirty dishes from the first shift.

On [illegible] at 12:03 p.m. a resident was observed with arms crossed and standing at the end of a table that still had 4 residents seated at it. Two of the residents got up and left the dining [illegible] those seats were not the ones the resident standing at the end of the table wanted. It was observed she was waiting for the female resident to leave however the resident was still eating her lunch. The resident was observed to be staring at the female resident and making mumbling sounds under her breath. The resident stood there staring at the female resident until 12:08 p.m. when the female resident got up and left. It was also observed she still had food on her plate.

On [illegible] at 12:10 p.m. the 2 aides started clearing the dirty dishes on the tables from the first shift while the second shift residents sat at the tables.

On [illegible] at 12:25 p.m. it was observed the first lunch tray was delivered by one aide and the second aide was serving coffee table to table. It was observed there was only the 2 aides in the dining [illegible] lunch to approximately 40 residents.

On [illegible] at 12:35 p.m. a resident was observed leaving the dining [illegible] stating as he was walking out 'They are so slow. It takes forever to get your lunch. How can one person do it all.'

4) On [illegible] at 11:46 a.m. a resident from the first shift was seated at a table close to the med tech's medication cart. It was noted he and the female resident across from him had plain spaghetti on their plates with no spaghetti sauce. Both residents were observed to be picking at the plain spaghetti. It was noted other residents eating the spaghetti did have a red sauce on their spaghetti.

At 12:08 p.m. the female resident got up and left. It was observed she still had a good portion of plain spaghetti on her plate.

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At 12:09 p.m. the male resident called over med tech 'D' and stated 'This is the worst meal ever, there was no meat.' It was noted he still had a good portion of plain spaghetti on his plate. Med tech 'D' responded by saying there is sauce in the little bowl that you were to put on your spaghetti. The resident looked embarrassed and said 'I didn't know that.'

During the first shift lunch meal observation it was noted not one staff member interacted with these 2 residents who are in the first shift, which per the Administrator, the first shift residents require assistance.

5. Resident #11 was not treated with respect and dignity. During observations on [redacted] at 11:05 a.m. in the "cares area" in the back of the main dining [redacted], there were 11 residents observed. Approximately 5 residents were seated in reclining chairs, approximately 5 in wheelchairs. Resident #11 was observed in the corner, seated at the table, but was blocked in by one of the residents in a recliner. The resident was [redacted] and kept standing up. During further observations on [redacted] at 11:30 a.m. resident #11 was observed still trapped in the corner by the resident in the recliner. The hospice aide and one of the facility aides were overheard telling resident #11 over and over to "sit down". At approximately 11:35 a.m. when staff were not watching, the resident attempted to climb over the resident in the recliner, actually putting her legs on top of the resident until surveyor requested staff intervention.

6. Additional observations of food service on [redacted] at 11:30 a.m. in the "cares" area of the dining [redacted] staff were observed bringing trays to the back of the dining [redacted] the residents were identified as requiring assistance. The trays were observed to contain bowls of either a brown or green substance. One of the full trays was placed on the table beside Resident #12 and Resident #18, just out of their reach. The staff member covered the tray with a plastic bib. Resident #12 tried to reach for the tray but was unable to. At the next table another tray with several bowls of pureed foods was placed in the middle of the table, out of reach of the four residents seated there. The hospice aide was observed bringing a resident in a recliner chair to the table next to the other 4 residents and began to feed the resident, in full view of the residents at the table, who had not been served yet. The residents also were observed reaching for the food, and meanwhile were not served and had to watch the hospice aide feed the resident. At 11:45 a.m. the administrator was requested to come to the dining [redacted] assist the staff and observe resident #11 trapped at the table.

7. On [redacted] at 9:05 a.m. in the back of the dining [redacted] the "cares" area, staff member "C" was observed present with approximately 10 residents. Resident #18 was observed in a wheelchair and said that he was stuck and needed the wheelchair brake released. The resident's left arm was observed to be contracted. The resident then asked the staff member but she did not understand English, saying "I speak little English". She asked him a question in another language, and he said

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back to her that he did not understand. Further observations revealed that the hospice aide and staff member "C" were speaking continuously to each other in another language, in disregard to resident #18 and another English speaking resident, resident #12. The administrator was interviewed on at 1:30 p.m. and provided no additional information.

8. During interviews with residents conducted on and , 7 out of 11 residents complained about the food. The resident council minutes and grievance log were requested and reviewed. The complaint log only contained one entry for 2014, and that was notes from the resident council meeting dated that documented the residents requested better quality ground meat, no more bologna, no stewed fish, and more spaghetti sauce. The residents also complained that the menu was not being followed for the pork chops, salisbury steak, and pie. There was no documentation of the facility response.

On at 2:30 p.m. the administrator was interviewed and said that a meeting was being arranged with the dietitian in response, but she could not explain the reason for the delay. When asked for any other complaints or resident council notes for 2014, and the facility's response, she stated she had them on her desk. As of at 4:00 p.m., no additional information was provided.

9. Resident #12's bed was observed with side rails on at 10:30 a.m. The resident's record was reviewed and there was no order for the use of the side rails. An interview was conducted with aide "A" on at 10:35 a.m. and she said she thought the order was in the hospice record but was unable to locate it.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation, interview and record review, the facility failed to ensure a resident who is self administering medications was assessed for competency to do so for 1 of 1 residents (Resident #6) reviewed for self administration of medications.

The findings include:

On at approximately 9:45 a.m. an interview was conducted with Resident #6 in her she shares with another resident. During the interview observation was made of 2 boxes of eye drops sitting on her night stand and a bottle of in the open top drawer of her nightstand. An inquiry was made to the resident if she is using any of these medications to which she responded she was using both of the eye drops and the bottle of was just extra as the facility provides her with that medication every morning. Review of the label on one of the eye drops, 0.2% an for revealed it was prescribed by a physician on with directions to instill 1 drop in each eye daily. The second box of eye drops was an over the counter medication labeled Natural Tears. A further inquiry was made to Resident #6 who stated she is using the

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eye drops every morning for and the Natural Tears twice a day for dry eyes. During the interview Resident #6 also pulled out of her top night stand drawer a bottle of nasal spray which she stated she uses once in a while when her are acting up.

Review of Resident #6's 1823 Health Assessment dated revealed under Section 2-B 'Does the individual need help with taking his or her medications?' blank with no indication of whether the resident required assistance with self administration of medications.

Review of the Medication Observation Record for Resident #6 revealed the eye drops and nasal spray are not documented as medications the resident is currently taking.

Review of Resident #6's record revealed no evidence of documentation the resident was assessed for competency to self administer medications.

On at approximately 1:00 p.m. an interview was conducted with the Administrator who stated she was not aware Resident #6 had or was using these medications and they will do an assessment.

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC

Based on record reviews and interviews, the facility failed to ensure that staff had documentation of freedom from communicable for 1 of 4 personnel records reviewed (staff member F).

The findings are:

During a review of the personnel records it was noted that Staff member F was hired The only documentation of the staff member's communicable status was a statement from a health care provider that was dated more than a year prior to the date of hire. The Administrator was interviewed on at 3:30 p.m. and no additional information was provided.

Class III

0079-Staffing Standards - Levels 58A-5.019(3) FAC

Based on observations, interviews and record reviews, the facility failed to maintain the minimum required staff hours per week to ensure residents' needs were met for the LMH, LNS and residents in the main dining In addition, the facility failed to comply with the additional staffing requirements of facilities holding a limited mental health (LMH) and limited nursing services (LNS) license. For LNS, 3 of 3 sampled residents records identified by the facility as receiving Limited Nursing Services, Residents #5, #6, and #7, did not have documentation of assessments and progress notes. For LMH, 2 of 2 residents (#5 and #15) did not have documentation of up to date community living support plans.

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The findings are:

1. On [redacted] at 9:10AM the census, list of LMH and LNS residents and staff schedule were requested. It was noted that there were approximately 55 LMH residents, and approximately 6 residents listed for LNS. Refer to L 278: LNS records, documentation of assessments and progress notes were not completed for 3 of 3 sampled residents records reviewed identified by the facility as receiving Limited Nursing Services, Residents #5, #6, and #7. Refer to L 241, 2 of 2 residents (#5 and #15) did not have documentation of up to date community living support plans. In addition, deficient practice was identified for failure to provide activities as scheduled (refer to A 26).

2. The staff schedule was reviewed and the hours listed for the current week added up to 555 (including a 30 minute break). For a census of 98, the required amount would be 581. The Admnistrator was interviewed on [redacted] at 3:30 p.m. and acknowledged the findings.2. On [redacted] at 10:30 AM, an interview was conducted with Resident #6 who stated there are only 2 staff members during the night shift for all these people. She stated she can look after herself but there are a lot of residents that need their diapers changed and need help getting into bed. She stated she does not know how the staff do it and hopes that it is not affecting any residents.

3. On [redacted] at 11:40 AM, an interview was conducted with Resident #19 who stated sometimes the staff are abrupt but that is probably because there is not enough of them for this many people living here. He stated he can do everything for himself. However, there are a lot of residents who need help like the ones in wheelchairs.

4. On [redacted] at 10:00 AM, during the initial facility tour with the Administrator the dining [redacted] observed. The Administrator stated the first shift lunch begins at 11:30 AM for those residents who require assistance and the second shift lunch from 12:00 PM to 12:45 PM is for those residents who are independent.

On [redacted] at 12:00 PM, residents from the first shift lunch were observed still in the dining [redacted] some of which were still eating. It was noted there were only 2 aides assisting in the dining [redacted] one handed out meal trays and the other was walking around with a coffee pot. On [redacted] at 12:02 PM, observation was made of residents on the second shift piling into the dining [redacted] going straight to the tables that they usually eat at. It was observed the dishes from the first shift had not been cleared yet and residents from the second shift were sitting at tables with the dirty dishes from the first shift.

On [redacted] at 12:10 PM, the 2 aides started clearing the dirty dishes on the tables from the first shift while the second shift residents sat at the tables. On [redacted] at 12:25 PM, it was observed the first lunch tray was delivered by one aide and the second aide was serving coffee table to table. It was observed there was only the 2 aides in the dining [redacted] lunch to approximately 40 residents. On [redacted] at 12:35 PM, a resident was observed leaving the dining [redacted] stating as he was walking out 'They are so slow. It takes forever to get your lunch. How can one person do it all?'

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5. On . . . . . at 11:46 AM, a resident from the first shift was seated at a table close to the med tech's medication cart. It was noted he and the female resident across from him had plain spaghetti on their plates with no spaghetti sauce. Both residents were observed to be picking at the plain spaghetti. It was noted other residents eating the spaghetti did have a red sauce on their spaghetti. At 12:08 PM, the female resident got up and left. It was observed she still had a good portion of plain spaghetti on her plate. At 12:09 PM, the male resident called over med tech 'D' and stated 'This is the worst meal ever, there was no meat.' It was noted he still had a good portion of plain spaghetti on his plate. Med tech 'D' responded by saying there is sauce in the little bowl that you were to put on your spaghetti. The resident looked embarrassed and said 'I didn't know that.'
During the first shift lunch meal observation it was noted not one staff member interacted with these 2 residents who are in the first shift, which per the Administrator, the first shift residents require assistance.

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on record reviews and interviews, the facility failed to ensure that direct care staff members had the required in-service trainings, for 1 of 3 direct care staff records reviewed (staff member F.)

The findings are:

During a review of the personnel records it was noted that staff member F, a direct care staff, hire date . did not have the following required in-service trainings within 30 days of the date of hire: 1 hour safe food handling practices, 3 hours of in-service training in Resident behavior and needs, Providing assistance with the activities of daily living, Resident rights in an assisted living facility, and Recognizing and reporting resident , neglect, and .

The Administrator was interviewed on . . . . . at 3:30 PM and no additional information was provided.

Class III

0082-Training - 58A-5.0191(3) FAC
Based on record reviews and interviews, the facility failed to ensure that staff had documentation of a one time course in . . . and . for 1 of 4 personnel records reviewed (staff member E).

The findings are:

During a review of the personnel records it was noted that staff member E, who worked in the kitchen, was hired . . . . . The personnel record did not contain documentation of the required . . . and training. The Administrator was interviewed on . . . . . at 3:30 PM and no additional information was

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provided.

Class III

0090-Training - 58A-5.0191(11) FAC
Based on record reviews and interviews, the facility failed to ensure that direct care staff members had the required orders training for staff members B, C, and F, all hired more than 30 days ago.

The findings are:

During a review of the personnel records it was noted that of three direct care staff records reviewed, B, C and F, none had the required training. Staff member B had a hire date of , staff member C had a hire date of and staff member F had a hire date of , more than 30 days ago.

The administrator was interviewed on at 3:30 PM and no additional information was provided.

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on observations, interviews and record reviews, the facility failed to ensure that the menu was followed and that menu subsitutions were of comparable nutritional value.

The findings are:

1. On during lunch time observations, it was noted that a dish of red gelatin was being served to the residents. On the menu the food item "fresh fruit" was crossed out and "jello" was written in. On at 12:35 PM, the cook for the day was interviewed and said there was no fresh fruit available today.
2. On at 9:00 AM, the menu was reviewed and documented that "french toast" was to be served. During observations of the remaining residents still at breakfast it was noted that they were being served english muffin and cereal. On at 9:30 AM, the cook for the day was interviewed and stated there was no bread for the french toast so she served english muffins instead. When asked if the english muffin was made with the same recipe as the french toast to include some protein source, she stated she did not understand the question.

On at 10:00 AM, the Administrator was interviewed and agreed that the substitutions were not nutritionally equivalent.

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0161-Records - Staff 58A-5.024(2) FAC
Based on record reviews and interviews, the facility failed to ensure that staff had documentation of a job description, for 1 of 4 personnel records reviewed (staff member F).

The findings are:

During a review of the personnel records it was noted that staff member F was hired . The personnel record contained no job description and per the staff schedule the staff member worked as an aide on the night shift.

The administrator was interviewed on at 3:30 PM and no additional information was provided.

Class III

0162-Records - Resident 58A-5.024(3) FAC
Based on interview and record review, the facility failed to ensure resident records were complete to include documentation resident weights were done on a semi-annual basis for 6 sampled resident record reviews (Residents #6, #7, #9, #10, #12 and #15) who receive assistance with activities of daily living.

The findings include:

On and resident records were reviewed to reveal the following:

1) Resident #6 was admitted to the facility on . Review of the Resident Weight Record revealed the last documented weight dated is 174 pounds. The resident's prior weight dated is documented as 183 pounds. Review of the resident's record revealed no evidence of documentation addressing the 9 pound weight loss in 5 months and no evidence of additional weights after .

2) Resident #7 was admitted to the facility on . Review of the Resident Weight Record revealed the last documented weight dated is 242 pounds. Further review of the record revealed no evidence of documentation of any additional weights since his admission.

3) Resident #9 was admitted to the facility on . Review of the Resident Weight Record revealed on his weight was 162 pounds. The last documented weight on the weight record dated is 138 pounds. Review of the resident's record revealed no evidence of documentation addressing the 24 pound weight loss in 5 months and no evidence of additional weights after .

4) Resident #10 was admitted to the facility on . Review of the Resident Weight Record revealed the last documented weight dated was 120 pounds. Further review of the record revealed no evidence of documentation of any additional weights.

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5) During record review of resident #15's record , it was noted that the resident receives assistance with activities of daily living and so is required to have semiannual weights documented. The resident was admitted to the facility on . . . . . The last weight in the record was from , more than 6 months ago. The administrator was interviewed on at 1:30 p.m. and no additional information was provided.

6) During record review of resident #12's record, it was noted that the resident requires assistance with the activities of daily living. There were no weights documented in the resident's record after , more than a year ago. The administrator was interviewed on . . . . . at 1:30 p.m. and no additional information was provided.

On . . . . . at approximately 3:00 PM, an interview was conducted with staff member 'A' who confirmed the only place there would be weight documentation is on the Resident Weight Record in the resident's chart. She confirmed all of aforementioned resident's require assistance with ADLs.

Class III

L241-LMH - Records 58A-5.029(2) FAC
Based on record reviews and interviews, the facility failed to ensure that the Community Living Support Plans (CLSP) were updated at least annually, for 2 of 2 residents (Resident #5 and Resident #15).

The findings are:

1) Resident #5's record was reviewed and documented that the resident was admitted to the facility on . . . . . The Agreement and Community Living Support Plans (CLSP) were not in the resident's record. The documentation was requested and provided. The CLSP was noted to be dated , over a year ago.
2) Resident #15's record was reviewed and documented that the resident was admitted . . . . . The Agreement and Community Living Support Plans (CLSP) were not in the resident's record. The documentation was requested and provided. The CLSP was noted to be dated , over a year ago.

The Administrator was interviewed on . . . . . at approximately 1:30 PM and provided an updated CLSP dated , the date of the survey, for both residents, but could not explain why the CLSP was not updated at least annually as required.

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N278-LNS - Records 58A-5.031(3) FAC
Based on observation, interview and record review, the facility failed to ensure Limited Nursing Services (LNS) records, documentation of assessments and progress notes were completed, for 3 of 3 sampled residents records reviewed identified by the facility as receiving Limited Nursing Services (Residents #5, #6, and #7).

The findings include:

On [redacted] on initial entrance to the facility a request was made to the Administrator for a list of their residents receiving LNS. A hand written list on a piece of loose paper was provided identifying 6 residents as receiving LNS.

On [redacted] at 10:15AM, during the initial tour with the Administrator observation was made of an [redacted] concentrator and [redacted] tubing sitting next to the bedside for Resident #10. Review of the LNS list provided revealed she was not listed as receiving LNS. Review of her record revealed no physician order for LNS and no documentation regarding the [redacted]. During an interview with the Administrator at this time, she stated that the facility has no nurses on duty at the facility; only the on-call LNS nurse.

On [redacted] at 10:30 a.m. an interview was conducted with Resident #6, identified on the list as receiving LNS. The resident stated she is not receiving any nursing services and is just getting physical [redacted] for her hip. Review of her record revealed no physician order or documentation related to LNS.

On [redacted] at 10:45 a.m. an interview was conducted with Resident #7 who stated he gets [redacted] injections daily by a nurse from a home health agency. He stated he has not been seen by any nurse from the facility. Resident #7 is identified on the facility list of residents receiving LNS. Review of his record revealed no physician order or documentation related to LNS.

Resident #5, identified on the LNS list, is receiving [redacted] injections twice daily by a nurse from a home health agency. Review of his record revealed no physician order or documentation related to LNS.

On [redacted] at 11:20 AM, an interview was conducted with the Hospice Registered Nurse who stated Resident #9 has a [redacted] to his sacrum. Review of the LNS list provided revealed he was not listed as receiving LNS. Review of his record revealed no physician order for LNS and no documentation regarding the sacral [redacted].

On [redacted] at 1:00 PM, an interview was conducted with the Registered Nurse (RN) identified as being the LNS Supervisor. She stated she just took on this role since [redacted] and has been trying to make some changes. Review of the contract designating her as the LNS Supervisor is signed and dated [redacted]. She stated the LNS residents are seen by home health which is overseen by her, the LNS Supervisor. An inquiry was made which residents were currently identified as receiving LNS and she stated she was not quite sure about that and would have to check. A request was made to review where she documents and keeps track of the LNS residents and she stated 'it looks like they had a log but it looks like all those residents are no longer here.' A request was made to review her initial

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assessments, any progress notes or monthly assessments and she stated she has not assessed any residents as yet. An inquiry was made if she was aware Resident #9 has a pressure and Resident #10 has at her bedside to which she replied she was not aware of these 2 residents.

On at approximately 3:00 PM, during the exit conference the RN LNS Supervisor stated she has a list and has assessed all the residents identified as receiving LNS in addition to Residents #9 for the and #10 for the She stated she was not aware a physician order was required so that will also be taken care of.

Review of the facility Policy for Limited Nursing Services states in part, 'The LNS nurse is designated responsible for general supervision of nursing services provided to LNS residents. The LNS nurse must participate in the development of service plans. The LNS nurse is required to perform or supervise the performance of the nursing assessments at least monthly and report the findings to the administrator. The LNS facility maintains records in addition to those required of a standard facility to include a Log containing a list of residents receiving LNS services.'

Review of the Resident Contract documents 'The facility is also licensed to provide LNS Services. These services include - monitoring of health status, nursing intervention, medication assistance, arrangements for health services or supplies.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Administrator
Midtown Manor
2001 Polk Street
Hollywood, FL 33020

RE: Change of Ownership Survey

Dear Administrator:

This letter reports the findings of a change of ownership survey that was conducted on 18, 2014 and , 2014 by representatives 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 representatives. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

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