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	AL11910722	08/27/2014
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 - 0000 - - Initial Comments
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0026 - 58a-5.0182(2) Fac - Resident Care - Social & Leisure Activities S-S= D
St - A - 0032 - 58a-5.0182(8) Fac - Resident Care - Elopement Standards S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - 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 licensure complaint survey, CCR #2014005295, CCR #2014005611, CCR #2014005344 was conducted on at Lauderhill Manor. The facility had deficiencies found at the time of the visit.

Deficient practice identified at CCR #2014005295, CCR #2014005611, CCR #2014005344.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC

Based on interview, observation and record review, the facility failed to provide the care and services appropriate to the needs of the residents. As evidenced by the facility failure to reassess 4 of 4 sampled residents (Resident # 3, #4, #5 and #6) for continued residency after significant changes in behavior and medical condition to ensure that appropriate care and services were provided and that the facility could meet the resident's care needs.

The findings include:

1) Resident #3 was admitted to facility on from another facility. The resident had medical diagnoses including Parkinson, and unsteady gait. She required supervision for ambulation, bathing, toileting and medication management. The resident was assessed on admission to be an elopement risk, she had wandering behavior, poor acceptance of the admission, and a

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history of elopement at home. Facility interventions included: placement of ID bracelet, picture in log, staff awareness of elopement risk, and frequent monitoring.

Review of the progress notes reveals the resident is observed very nervous, entering other resident using others items and clothing. The physician is notified of the behavior. On at 11:30 PM the resident hitting her right eye with complaint of and is sent to the hospital for evaluation. She returns the following day to the facility. The resident remains unable to express needs and wishes.

On the resident receives a phone call from a family member and runs out of the building. Staff witness the behavior and run after the resident into the parking lot. The resident informs the staff that her sister told her to run out of the building and to go home. The facility staff inform the family of the incident. Review of the progress notes reveals no documentation that the physician was notified of the incident.

On at 10:30AM the resident's family visits and makes request for staff to keep resident from approaching the front door. The facility management advised the family that the facility is not a locked unit, and are informed that the resident may need more secure unit due to increased elopement concerns.

On at 2:10 PM the resident is observed to be nervous, wearing her clothes and shoes. She requests staff to let her go home to live with her sister. The staff attempt to redirect the resident, but she becomes verbally to staff. The resident is encouraged to speak with her family but becomes more agitated and begins to remove all of her clothing and placed in the facility laundry. The Administrator is notified of the incident, no documentation the physician was notified of the behaviors.

On at approximately 12:10 PM the Aide enters the residents direct her to the lunch meal and finds the resident not in the . The facility staff search the building and call the police at 1 PM. The search continues outside on the property with all staff and police and the family and administrator are notified. There is no documentation the facility informed the physician of the incident. On at 10:30AM the local police inform the facility that the resident had been found at a local park/ field. She is transferred to the hospital for evaluation with no apparent injuries. The resident did not return to facility.

On at approximately 10:00AM during an interview with the Administrator he stated that all residents identified at risk for elopement or have a history of elopement should have their picture in the

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log book and have an identification bracelet on their person. He stated that the staff was aware of those residents that require monitoring. He confirmed the facility policy was to place an identification bracelet on all the residents' at risk, which included the name and telephone number of the facility. He acknowledged the resident had been identified as an elopement risk but the care interventions had not been reevaluated with the increase in behaviors exhibited by the resident. He expressed the facility was reviewing the elopement policies.

The facility failed to document the physician had been informed of the ongoing behaviors and increased elopement risk for the resident. The facility did not document any additional interventions implemented for the safety of the resident.

2. Resident #4 was admitted to the facility on with medical diagnosis including and unsteady gait. The Parkinson, resident is independent for ambulation, eating, transferring, and requires supervision with bathing, dressing,toileting and self care. He needs assistance with self administration of medications. Review of the medical record reveals numerous hospital admissions for behaviors, and complaint of pain. No risk assessment was completed for this resident on admission.

On at 11:30 AM the resident was observed in the lobby, his leg collection bag was hanging around his right ankle and the was stretched taut. After surveyor intervention, the Med Tech attempted to the reposition the bag. The resident became agitated and asked the staff to " pull the out."

Review of a evaluation dated reveal the resident has a history of and is increasingly and angry prior to admission. He had stopped taking the prescribed medications. He was experiencing of persecution,religious preoccupation, and was for demons.

Review of record on reveals the resident complains of severe pain and is transferred to the hospital for evaluation. On at 11:30 PM the resident is readmitted with a with a and treatment for On at 2:30AM the resident is observed attempting to pull out or cut the which causes The resident returns the same day with a new inserted. On at 7:35 AM the resident is transferred to the hospital for in the collection bag. On at 4:30AM the resident out of bed hitting his head. He is assessed to have no injuries and returns to the facility. He returns with no and is to be

monitored closely for changes in condition per discharge orders.

On the resident is documented as refusing all of his medications and requesting to go to the hospital. He is unable to express what is bothering him. He exits the facility and is found in the parking lot by a visitor. The resident is transferred to the hospital for right pain. The family requests a evaluation to be completed. The resident returns to the facility the same day. He is documented as very and hallucinating. He pulls the out and is transferred back to the hospital. The resident returns after having a new inserted. The physician is notified.

Review of the progress notes reveals no actions taken or interventions by the facility after the elopement incident. The resident was not evaluated for elopement risk yet he is listed on the elopement watch list by the facility. Interviews conducted with random staff revealed the resident is identified as an elopement risk. No documentation could be provided to address the re-evaluation of appropriateness of the resident after recurrent behavioral incidents and the facility ability to appropriately monitor the resident for safety regarding the

3. Resident #5 was admitted to the facility on with medical diagnoses including Prostatic Hyperplasia and The resident is alert and but at times. He requires assistance with all ADL care and needs assistance with self administration of medications. The resident has a history of aggressive behavior toward staff and is visited by staff at facility. He has a in place for retention and history of recurrent I's with multiple hospitalizations. The resident is ordered weekly Home Health nursing care for assessment and maintenance of the as well as lower extremity care. Also the resident is admitted to Limited Nursing Services (LNS) by the facility staff for care and monitoring.

On at 1:00 PM the resident was observed in lobby, his leg collection bag was hanging down by his ankle, the was stretched and taut. The Med Tech attempted to reposition the bag and escorts the resident to his observe the The is observed to be visually soiled from the collection bag to the insertion site. The was kinked inside the resident's under garments/clothing. The resident stated that he wanted to go to the hospital and complained of lower pain. The collection bag was empty and when he was questioned if he had emptied the bag, he was unsure. There was a strong smell of noted on resident and he had blackened soiled finger nails. The Med Tech stated she needed to have the resident transferred to

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hospital for evaluation.

An interview was conducted with an aide on at 3:30 PM, she states that she is responsible for the resident's ADL care and empties the collection bag but the resident cleans his own

Review of the medical record reveals numerous transfers to the hospital for retention and insertion. No documentation was noted by the facility about care or monitoring of function. Review of LNS notes reveals the resident was last seen by the LNS nurse on "resident readmitted with draining clear yellow into collection bag, no sign of noted". No additional documentation of LNS nursing care provided to monitor and care for the was provided.

Review of the Home Health Agency "Communication Notes" reveals no mention of an assessment, monitoring or care interventions of the since

4. Resident # 6 was admitted to the facility on with medical diagnoses of malignance, insufficiency, and recurrent T's. The resident is assessed to be alert and oriented but forgetful at times. He is independent for ADL care but requires assistance with care. The is changed monthly by the Home Health Agency nurse. The resident self administers his medications with the assistance from the LNS nurse who refills the pill box weekly.

On at approximately 10:00AM the resident was observed in his in his wheelchair. A strong smell of was noted upon entering the The resident was alert and oriented and stated that he is independent and self administers his own medication. He stated that the LNS Nurse refills his pill box weekly, but does not check his The facility staff assist him to empty the collection bag. He complained that he was experiencing leakage of from around the into his diaper. He opened his pants and showed the soiled diaper to the Med Tech and surveyor. With further questioning he stated that he had not seen any in the collection bag since returning from the hospital on and he complained of lower pressure. The Med Tech immediately notified the physician and the resident was sent to the hospital for evaluation.

Review of the facility progress notes reveals no documentation of care provided to monitor and care for the upon readmission on

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Review of the LNS Admission and Discharge Register log reveals the resident was placed on LNS services on ... for medication management. Review of the LNS progress note dated ... reveals resident admitted to hospital for hematuria. Review of prior notes reveals no observation or assessment of the ...

On ... at approximately 3:00 PM during an interview with the Administrator, he reviewed the LNS and medical records for the Residents #4, #5 and #6. He confirmed that the residents were admitted to LNS and should have the nursing care documented. He stated that there is no longer a nurse on staff and the aides have been supervising the residents for ... care. He was not aware of the lack of documentation of the daily assessments, monitoring, care given and the outcome to the resident. He acknowledged the residents should be monitored for ... care and documentation completed appropriately. During further interview, it was revealed aforementioned residents had not been reassessed for continued residency to ensure the facility could met the care needs of the residents.

Class III

0026-Resident Care - Social & Leisure Activities 58A-5.0182(2) FAC

Based on observation, interviews and record reviews, the facility failed to ensure that scheduled activities were available at least 6 days a week for a total of not less than 12 hours.

The findings are:

During the tour of the facility on ... the activity calendar was observed posted in the main lobby area. The activity calendar was reviewed and documented that the activities were only scheduled 4 days a week, on Tuesday, Thursday, Friday and Saturday. The Activity Director was interviewed on ... at approximately 12:45 PM, she stated that she was not a full-time employee and worked only on Tuesday, Thursday, Friday and Saturday.

On ... at approximately 3:00 PM, random interviews were conducted with alert residents sitting on the main lobby area. The residents expressed that there were not enough activities or variety of activities planned on a daily bases. They expressed that they were bored with just watching TV or

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movies.

The Administrator was interviewed on . . . at approximately 2:30 p.m. and said that the activity program is a "work in progress" and additional programs are being added.

Class III

0032-Resident Care - Elopement Standards 58A-5.0182(8) FAC

Based on observation, interview and record review, the facility failed to properly identify those residents that are determined by the facility at risk for elopement.

The findings include:

On . an observation was made of the facility's printed list of residents identified as an elopement risk. The facility log book revealed photos and names of 18 current residents determined by the facility to be at a high risk for elopement.

Observations conducted during the survey on . . . - identified the front door remains unlocked with open access to the facility. A receptionist was observed sitting at the main desk adjacent to the doorway during the business hours.

On . at approximately 11:00 AM, an interview was conducted with the Receptionist who stated that she is aware of the residents that are at risk for elopement, and their photos are placed in the log book. She stated that a bracelet is placed on the resident with identification and facility telephone number. She stated that all staff are aware of the residents who are identified at risk for elopement. She confirmed the door is locked when the Administrative staff leave for the day.

Further observations conducted on . . . and . . . revealed the 18 residents identified as elopement risks, were observed to have no identification bracelet on their persons, that included their name and the facility ' s name, address and telephone number. The residents were unable to express where the bracelets were.

On . . . at approximately 10:00AM during an interview with the Administrator, he stated that the

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residents identified at risk for elopement or have a history of elopement should have their picture in the log book and have an identification bracelet on their person. He stated that the staff were aware of the residents that require monitoring. He confirmed the facility policy was to place an identification bracelet on all the residents' at risk, which included the name and telephone number of the facility. He stated that the residents do not like the bracelets and remove them. He acknowledged that the residents should have some form of identification on them at all times. He expressed the facility was reviewing the elopement policies.

Class III

0054-Medication - Records 58A-5.0185(5) FAC

Based on observation, interview and record review, the facility failed to maintain accurate daily medication observation records (MORs) for all residents that require assistance with self-administration. As evidenced by facility failure to accurately document medications prescribed by the physician on the MOR, for 2 of 3 sampled residents (Resident #1 and #7).

The findings include:

1) Resident #1 was admitted to the facility on with medical diagnoses of . The resident is alert and oriented to self only and required assistance with medication administration.

Review of the progress notes reveal a evaluation was completed on . The findings included the resident has with behavior disturbances. Medications were ordered, 0.25 mg by mouth twice a day and 18 mg once a day.

Record review of the Medication Observation Record (MOR) for 2014 reveals the resident was administered the 0.25 mg starting on at 5 PM. The prescribed 8 AM morning dose of medication was not administered on and .

An interview was conducted with the Med Tech on at 11 AM, she reviewed the MOR but could not recall why the resident had not received the morning doses of the . The medical record was reviewed, no documentation was found that the staff notified the physician the resident had

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missed the prescribed doses.

2) Resident #7 was admitted to the facility on . . . with medical diagnoses of , and . The resident is alert and oriented ,with at times. He is independent for most ADL care, and needs assistance with self administration of medications. On . . . at 8 PM the resident . . . and sustains a head injury requiring evaluation at the hospital. The resident is prescribed . . . mg every 6 hours as needed for pain. Review of the 2014 MOR reveals the resident was administered the . . . 10 times on 8 days with no documentation of the time the medication was given or effectiveness.

On . . . at approximately 3:30 PM during an interview with the Med Tech, who signed the MOR, he confirmed that he administered the medication. He stated that he had forgotten to make note of the time the medication had been given. He acknowledged that the . . . had specific time parameters prescribed by the physician, which must be follow.

On . . . at approximately 2:00 PM during an interview with the Administrator, he acknowledged that the staff must accurately document in the MOR following acceptable pharmacy guidelines.

Class III

N278-LNS - Records 58A-5.031(3) FAC

Based on observation,interview and record review, the facility failed to maintain required Nursing Progress Notes and monthly Nursing Assessment for resident care, for 3 of 3 sampled residents (Residents #4,#5 and #6) receiving Limited Nursing Service (LNS).

The findings include:

1) Resident #4 was admitted to the facility with medical diagnosis including , Parkinson, , and unsteady gait. The resident is independent for ambulation, eating, transferring, and requires supervision with bathing, dressing,toileting and self care. He needs assistance with self administration of medications. Review of

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the medical record reveals numerous hospital admissions for behaviors, and complaint of pain.

Review of the LNS Admission and Discharge Register log reveals the resident was placed on LNS services on for monitoring and care. The resident has a history of and noncompliance for self care of the

Review of the LNS progress notes reveal a note dated which notes the resident has and currently on The is described as patent, draining clear yellow with no signs of noted.

Review of the progress notes after reveals no documentation of LNS nursing care provided to monitor and care for the

2) Resident #5 was admitted to the facility on with medical diagnoses including Prostatic Hyperplasia and The resident is alert and but at times. He requires assistance with all ADL care and needs assistance with self administration of medications. The resident has a history of aggressive behavior toward staff. He has a in place for retention and history of recurrent I's with multiple hospitalizations. The resident is receiving weekly Home Health nursing care for assessment and maintenance of the as well as lower extremity care.

Review of the LNS Admission and Discharge Register log reveals the resident was placed on LNS services on for monitoring and care. The resident has a history of and noncompliance for self care of the

Review of the LNS progress note dated reveals resident was readmitted with draining clear yellow into collection bag, no signs or symptoms of noted. Review of the progress notes after reveals no documentation of LNS nursing care provided to monitor and care for the

Review of the Home Health Agency Communication notes at the facility reveals no mention of assessment, monitoring or care interventions of the since

3) Resident # 6 was admitted to the facility on with medical diagnoses of malignance,

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insufficiency, and recurrent T's. The resident is assessed to be alert and oriented but forgetful at times. He is independent for ADL care but requires assistance with care. The is changed monthly by the Home Health nurse. The resident self administers his medications with the assistance from the LNS nurse who refills the pill box weekly.

Review of the LNS Admission and Discharge Register log reveals the resident was placed on LNS services on for medication management.

Review of the LNS progress note dated reveals the resident was admitted to hospital for hematuria. Review of prior LNS notes reveals no observation or assessment of the Review of the facility progress notes reveals no documentation of care provided to monitor or care for the

On at approximately 3:00 PM during an interview with the Administrator, he reviewed the LNS log and medical records for the Residents #4, #5 and #6. He confirmed that the residents were admitted to the LNS and should have documented nursing care. He stated that there is no longer a nurse on staff and the aides have been supervising the residents for care. He was not aware of the lack of documentation of the daily assessments, monitoring, care given and the outcome to the resident. He acknowledged the residents should be monitored for care and documentation completed appropriately.

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RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

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

RE: CCR #2014005295, CCR #2014005611 & CCR #2014005344

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on 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

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