STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910722	02/03/2015
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 - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced licensure complaint survey, CCR#2014010976, was conducted on [redacted] at Lauderhill Manor. The facility had deficiencies found at the time of the visit related to the allegations.

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation and interview, the facility failed to ensure medications were securely stored at all times. As evidenced by observation of open bins of medications in plain view in the nursing station area and accessible to any person entering the area.

The Findings Include:

On [redacted] at 11:15 AM, a request was made to the day shift medication technician 'A' (med tech) to observe the medication storage area. Upon entering the nursing station area through a locked door with a wobbly door knob, observation was made of a medication cart which med tech 'A' stated is used for the morning and afternoon medications. She then proceeded to unlock a second door, with a wobbly door knob, which was in the same line directly in front of the first door. Upon opening this door, observation was made of two forty five gallon plastic bins, one uncovered and overflowing with [redacted] packs of medications and the other bin filled to the top with medications in addition to medications stacked in a cardboard box, medications in a large plastic bag and a pile of medications sitting loosely on top of the bin. These 2 bins could be observed from the entrance door through to the nursing station area and out to the main lobby area. Additionally, there was a large clear plastic bag filled with medication bottles and [redacted] packs on the floor next to where the resident records are housed, and more loose medications observed on top of the filing cabinet. Observation was made of another medication cart which med tech 'A' stated is used on the evening shift. Also observed next to the overflowing bin of medications was a [redacted] med tech 'A' stated is for staff.

Upon randomly picking up a medication from the uncovered bin the medication [redacted] pack was partially full and labeled [redacted] medication). The name on the [redacted] pack was referenced with the facility current census to reveal the resident was discharged on [redacted] Another

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medication was randomly picked up and the medication pack was partially full and labeled mg (pain medication). The name on the pack was referenced with the facility census to reveal the resident currently resided in the facility. During this observation it was noted residents were coming up to the nursing station area while med tech 'A' was assisting residents with the administration of morning medications. The overflowing bins of medications could be observed by the residents who came up to the nursing station in addition the bins could be observed by residents passing the nursing station area. An inquiry was made to med tech 'A' where all these medications came from and she stated they went through the resident medications for and these are all medications that have to go back to pharmacy. An inquiry was made how long it takes the pharmacy to deliver a new medication and she stated they usually receive the delivery the same day. An inquiry was made why the pharmacy has not picked up these bins of medications if they come almost on a daily basis and she stated the pharmacy has a small car and cannot fit these bins, then stated she has called the pharmacy to pick up the medications and they should come today.

On at 11:18 AM, med tech 'B' entered the nursing station and an inquiry was made where all these medications came from and he stated they are just the medications that have to go back to pharmacy. An inquiry was made how there could be so many medications to go back to pharmacy from one month and he stated the residents are on a lot of medications here. He further stated during the interview the residents don't know the medications are here, while residents were observed passing the open door to the nursing station area with the overflowing bins of medications in plain view. Med tech 'B' stated residents don't come into this An inquiry was made what about at night time when there are less staff visible and med tech 'B' stated they have 4-5 aides at night and a supervisor, however, concurred that if there was an emergency at night that tied up the staff a resident could potentially gain access to this the unsecured medications if they picked the lock. Med tech 'B' did reveal that they do have a few residents that could potentially be drug seeking.

On at 11:25 AM while med tech 'A' was assisting residents who came up to the nursing station door for their medications, the door remained open leading to the area where the overflowing bins of medications were stored.

Additionally, it was observed that non- facility staff personnel to include home health agency personnel and physician assistants were observed entering this , where the unsecured medications were stored, to obtain resident records and to use the in so doing had access to the medications stored unsecurely in the 45 gallon plastic bins and laying loosely around the area.

On at 12:30 PM, an interview was conducted with the Administrator who concurred that not only facility staff walk into the nursing station where the unsecured medications were stored, third party vendors such as home health agency staff, hospice staff, and physician assistants also go into that

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to retrieve resident records and to use the could potentially help themselves to the medications. He stated they really do not have any form of documentation of what medications are being returned to the pharmacy, they just load them up in the bins and the pharmacy comes to pick them up. He stated he has called the pharmacy and they will come to pick up the medication returns today. An inquiry was made how does the pharmacy know what medications are being returned and the reason for the return to which he did not have any response.

On at 1:00 PM, the nursing station observed from the main door of the nursing station to reveal three 45 gallon plastic bins with their lids secured and stacked on top of each other. Per med tech 'B' the pharmacy driver will be at the facility soon to pick up the medications.

Class III

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

Based on observation, interview and record review, the facility failed to ensure medications for assistance with the administration of medications were available for 2 of 3 sampled residents, (Resident #2 and Resident #3); and failed to ensure physician orders for medications were followed for 2 of 3 sampled residents (Resident #2 and Resident #3).

The Findings Include:

1) Resident #2 was admitted to the facility on with diagnoses to include leg amputation and chronic neck and back pain.

Review of the Medication Observation Record (MORs) for 2015 revealed an order for (sleeping pill) 7.5 mg at bedtime with documentation it was administered routinely at 8:00 p.m. every night. Review of the MOR revealed the was not signed off as administered/received.

On at 11:30 AM, an interview was conducted with Resident #2 who stated sometimes there is a problem with her medications not being available. An inquiry was made if she has been receiving her sleeping pill the last 2 nights and she stated that is an example of her not getting her medications and that she did not receive it and was not sure exactly why she did not get it. She stated she needs the sleeping pill and has not slept well the last 2 nights without it. She stated when she goes to bed her mind races

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and the pill helps to settle her down. The resident looked slightly agitated and restless and she confirmed that is how she feels right now in addition to feeling tired.

On at 1:17 PM, an interview was conducted with med tech 'B' who confirmed Resident #2 did not receive the the last 2 nights because they did not have it and further stating the reason was pharmacy said 'they' no longer cover the 7.5 mg so they waited for the physician to come in today and got an order for 15 mg. An inquiry was made to med tech 'B' if 'they' would not cover the 7.5 mg dose how are 'they' going to cover the 15 mg dose to which he stated 'they' probably are not making the 7.5 mg dose anymore. It was never determined through inquiry to med tech 'B' who 'they' was. Med tech 'B' produced a Physician Order Sheet dated stating 'Discontinue Temazapam 7.5 mg at bed time, may give 15 mg at bedtime for sleep.' The order was noted to not be signed by a licensed practitioner. Review of the resident's record revealed an order by the ARNP dated to 'Discontinue 15 mg at bed time due to . This order was brought to the attention of the Administrator and med tech 'B'. The Administrator stated they will clarify the new 15 mg order with the physician to see if it is alright to receive the 15 mg dose.

Review of the Resident Observation Notes for Resident #2 revealed documentation on at 3:30 PM, 'Resident came to med office, complains of severe neck pain, requested to go to ER.' Resident #2 was sent to the hospital for evaluation. Review of the Resident Observation Notes dated at 6:00 PM documents, 'Resident returned with discharge papers with her and prescriptions.' Review of the hospital discharge instructions dated documents a prescription for the medication Flexeril (muscle relaxant) 10 mg every 8 hours as needed for a diagnosis of chronic neck pain, muscle strain. Review of the 2014, 2015 and 2015 MORs revealed no evidence of documentation for the new medication order for the Flexeril.

On at 1:40 PM, an interview was conducted with the Administrator who stated the Flexeril was only for 5 days so it would be finished already. The prescription was viewed in the presence of the Administrator and it was pointed out the order was for every 8 hours as needed and not just for 5 days. The Administrator then stated he could not explain why the Flexeril was not on the MOR and stated it looks like they did not send the prescription to the pharmacy to be filled.

On at 3:30 PM, an interview was conducted with Resident #2 inquiring if she had ever received the Flexeril that was ordered after her visit to the hospital in to which she stated she thought she received it but was not sure. She further stated she has taken Flexeril in the past and it gives her

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relief from her neck pain.

2) Resident #3 was admitted to the facility on [redacted] with diagnoses to include [redacted] and [redacted].

Review of the resident record revealed a physician order dated [redacted] for Vicodan ES 7.5/[redacted] mg one tab every 6 hours 'as needed' for moderate pain. Review of the MORs for [redacted] 2015 the Vicodan ES 7.5/[redacted] mg order is hand written documenting the frequency to be every 6 hours 'as needed' with administration times documented routinely at 8 AM, 12 PM, 5 PM and 8 PM and not administered on an 'as needed' basis. Additionally, the Vicodan ES administered at 8 AM and then at 12 PM there is only 4 hours between doses and not 6 hours as ordered. Between the 12 PM and 5 PM doses there is only 5 hours between doses and not 6 hours as ordered. Between the 5 PM and 8 PM doses there is only 3 hours between doses and not 6 hours as ordered.

Review of the pharmacy computer generated MOR for [redacted] 2015 revealed the Vicodan ES was documented as 7.5/[redacted] mg and continued to be administered routinely at 8 AM, 12 PM, 4 PM and 8 PM and not administered on an 'as needed' basis as ordered. Additionally, the Vicodan administered at 8 AM and then at 12 PM there is only 4 hours between doses and not 6 hours as ordered. Between the 12 PM and 4 PM doses there is only 4 hours between doses and not 6 hours as ordered. Between the 4 PM and 8 PM doses there is only 4 hours between doses and not 6 hours as ordered.

On [redacted] at 11:20 AM, an interview was conducted with Resident #3 who confirmed she was receiving the Vicodan 4 times a day routinely for generalized pain and hip pain.

On [redacted] at 3:00 PM, an interview was conducted with med tech 'A' who confirmed Resident #3 was receiving the Vicodan routinely 4 times a day. An inquiry was made if the physician was notified the resident was taking the medication routinely 4 times a day and not on an 'as needed' basis to which she responded she does not believe the physician is aware but he should be coming in the next day or two. A further inquiry was made if the pharmacy has questioned the amount of Vicodan they are dispensing to which she responded they have not. A request was made to review the amount of Vicodan the facility currently had available. Review of the Vicodan [redacted] packs revealed there was 2 day supply left if the resident is taking them routinely 4 times a day. An inquiry was made to med tech 'A' if they have submitted a renewal request to the pharmacy before the Vicodan runs out to which she replied they have not as they are waiting on the physician to come in and he may have to change the order because there are issues with the resident's insurance company not going to cover a brand name so the doctor may have

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to order something else. An inquiry was made when the physician visits and she stated the ARNP usually comes in weekly and the physician comes in 2 times a month. She then stated the ARNP cannot order a ..... medication so they have to wait for the doctor, however, she was not sure when the doctor was going to visit.

On ..... at 3:30 PM, an interview was conducted with the Administrator who concurred the ARNP cannot order , it is only the physician that can do so. An inquiry was made if they are contacting the physician for Resident #3 to renew the order for the Vicodan before it runs out to which he replied they are waiting for the physician to come in and then further stated they have a Licensed Nurse that comes to the facility weekly on Fridays who could take an order over the phone. He stated he is aware that when someone is taking ..... on a routine basis you cannot just stop them. He stated he will address the issue before the medication runs out and make sure the doctor is aware the resident is taking the Vicodan on a routine basis.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

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

RE: CCR #2014010976

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on 2015 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 -Davis
Field Office Manager

AMD
Enclosure

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