STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910722	**03/19/2015**
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 TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced Licensure Complaint Survey, CCR#2014012300 & CCR#2015000021, was conducted on & at Lauderhill Manor. The facility had deficiencies found at the time of the visit related to the allegations for CCR#2014012300. The complaint surveys were conducted in conjunction with the revisit survey for CCR#20141010976. Refer to separate report.

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

Based on observation, interview and record review the facility failed to ensure resident records accurately reflected their condition for 2 of 4 resident records reviewed, (Resident #1 and Resident #4), as evidenced by no documentation of status for Resident #1 and Resident #4; and failing to inform the physician and resident's representative Resident #4 was sustaining

The Findings Include:

1) Resident #1 was admitted to the facility on with a diagnosis of and insufficiency. Review of the resident's record revealed an entry in the Resident Observation Log dated at 12 AM 'Resident found on the floor at the lobby. The right hand was cut and sent her to (name of the hospital).

Review of the facility Transfer Form dated documents the resident has 'Laceration on right and left hand.'Review of the Discharge Instructions from the hospital dated for Lacerations documents absorbable; start on (oral Further review of the Observation Log revealed no documentation when the resident returned from the hospital or the status of her right hand Review of Hospice orders dated documents to 'Remove soiled bandage, cover with nonadherent gauze and wrap with Kerlix every day.' Review of Hospice orders dated documents 'Dry dressing change to right hand 2 times a week. Discontinue previous dressing change orders. Monitor for signs of Review of the resident's record revealed no evidence of documentation by facility staff of the status of the resident's right hand The last entry in the record is dated the night she was found on the floor.

On at 3:53 p.m. an interview was conducted with the Administrator and the resident's chart reviewed. The Administrator concurred there was no documentation of when the resident returned from the hospital or any assessment of the resident's right hand and he further stated, 'She is on Hospice.'

On 15 at 4:42 p.m., Resident #1 was observed sitting up in a geri chair in the lobby area. The top of her right hand was observed to have a long laceration with dried red raised scabs. Resident #1 was not able to say how she got the

2) Resident #4 was admitted to the facility on with a diagnosis of decline in function and Review of the Health Assessment 1823 documents under /Nursing Treatment to include

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0025 Continued From page 1

'Cleanse right medial leg with normal , apply ointment, cover with gauze daily.'

Review of the initial admission assessment on the Resident Observation Log dated documents 'Resident admitted with a cut on right wrist close to the thumb, appears to be healing.' Further review of the initial assessment revealed no evidence of documentation of a on the right medial leg as documented on the 1823.

Further review of the Resident Observation Log revealed the following:
a) On at 11:05 p.m., the resident was found on the floor in the lobby. There is no evidence of documentation of an assessment of the resident post . There is no evidence of documentation the physician or family was notified.
b) On at 11:20 p.m. , he resident was found on the lobby floor. The resident was taken to the hospital via rescue and returned from the hospital at 3 AM. There is no evidence of documentation the physician or family was notified and no evidence of a physician order to transfer the resident to the hospital for evaluation. There is no evidence of documentation of an assessment of the resident post and no assessment of the resident upon return to the facility.
c) On at 4 AM, the resident slid out of bed and was helped back in. There is no evidence of documentation of an assessment of the resident post . There is no evidence of documentation the physician or family was notified.
d) On at 4:30 a.m., the resident slid out of bed and helped into wheelchair again. There is no evidence of documentation of an assessment of the resident post . There is no evidence of documentation the physician or family was notified.
e) On at 6:30 a.m., the resident slid out of bed and helped back into wheelchair. Documentation does state 'No injuries and refused hospital.'
The next entry in the Resident Observation Log is dated at 6:00 p.m., approximately 36 hours from his last episode documenting 'Due to previous resident complains of severe back pain. He requested to be sent to the hospital. Resident was transferred to hospital via ambulance.'

On at approximately 3:54 p.m., after reviewing the resident's record, the Administrator concurred there was no documentation of a to the resident's right leg and no documentation of any assessments of the resident after his .

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 maintain an environment that promotes control practices; failed to implement alternative measures to a to prevent for Resident #1; failed to address resident complaints related to the facility emergency call bell system; and failed to follow their protocol for Resident Rounds every 2 hours for Resident #4.

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	AL11910722	**03/19/2015**
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0030 Continued From page 2

The Findings Include:

1) On at 9:30 p.m. the woman's public the main lobby, for use by residents, staff and visitors, was observed. It was noted the door of the larger stall did not lock. This stall had a quarter roll of toilet paper available. The second smaller stall did not have any toilet paper. The automatic soap dispenser attached to the wall behind the sinks was empty. Two soap dispensers housed in the counter top were empty. A Purell hand sanitizer located on the wall next to the door was empty.
During the facility tour between 9:38 a.m. and 10:28 a.m. every wall mounted hand sanitizer was checked to reveal the following: The hand sanitizer between 109 and 111, 117 and 119, 123 and 125, 203 and 205, 209 and 211, 217 and 219, 224 and 226 were empty. The hand sanitizer in the dining observed at 10:30 a.m. and it too was empty. There were no wall mounted hand sanitizers on the 300s hallway.

On at 10:30 a.m. the woman's public observed to reveal the smaller stall did not have any toilet paper and did not have any soap in the 3 soap dispensers. At this time an aide came in and attempted to wash her hands however there was no soap to do so. At 10:32 a.m. the men's public observed with the aide to reveal there was no paper towels available for use.

On at 11:26 a.m. the woman's public observed to now have no toilet paper in either stall and no soap in the 3 soap dispensers.

On at 11:27 a.m., the housekeeper responsible for maintaining this interviewed who stated she checked that morning and she checks them 2 times a day, in the morning and around 1:30 p.m.

On at 12:10 p.m., the woman's public to have no toilet paper and no soap available for use.

On at 12:30 p.m., a telephone interview was conducted with the {confidential interview} representative who stated she has noticed that when she visits, there is never any hand sanitizer available for use. She stated she has to ask the front receptionist to use the hand sanitizer that is kept behind the front desk.

On at 2:15 p.m. the woman's public a half roll of toilet paper in the larger stall and a quarter of a roll in the smaller stall. There still was no soap available for use. A resident was observed to go to the sink and attempt to get soap from the soap dispenser, however, there was none. She stated this is an ongoing problem with not having toilet paper and soap and stated how am I supposed to get my hands clean, this should be stocked all day long.

On at 3:54 p.m., the Administrator was apprised of the lack of toilet paper, paper towels and soap in the public to which he responded housekeeping is supposed to do 2 rounds in the and further stated sometimes the residents take the toilet paper. He had no response to the lack of soap, paper towels or empty hand sanitizers. The Administrator was advised that the staff observed at 10:30 a.m. and 3:45

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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0030 Continued From page 3

p.m. to reveal the toilet paper holder was not attached to the wall and the toilet paper was sitting on the edge of the sink with the potential of being contaminated with dirty sink water. Additionally, there was no soap available in the wall mounted soap dispenser. There was a small piece of yellow brownish edged crusted piece of soap sitting in a brownish colored crusted soap dish. During the interview with the Administrator the day medication technician was present and she was asked what the staff uses for soap when they use the staff which she responded she does not know because she has her own soap that she carries around.

2) On at 11:23 a.m., an attempt to interview Resident #1 was made but she was in her bed sleeping. Her however was present and an inquiry was made if she knew anything about Resident #1's Resident #1's stated Resident #1 out of her wheelchair in the lobby and hurt herself. A geri reclining chair was observed in the corner of the the end of Resident #1's bed. An inquiry was made to the who's chair that belonged to, to which she responded, after Resident #1 out of her wheelchair, they put her in that chair so she couldn't out again. Review of Resident #1's record revealed no evidence of documentation of any alternative prevention measures implemented and no evidence of documentation for the initiation or use of the geri chair.

On 15 at 4:42 p.m. Resident #1 was observed sitting up in the geri chair in the front lobby area. The top of her right hand was observed to have a long laceration with dried red raised scabs. Resident #1 was noted to be and was not able to say how she got the . The positioning of the gerichair was tilted back slightly so as to prevent the resident from getting out of it.

3) On at 3:51 p.m. an interview was conducted with the Administrator inquiring about the resident call bell system and how long it has been non-functional to which he replied the system broke months ago and there was a problem with the internal wiring that caused the system to overload and short out and it almost started a fire. He stated they have not attempted to fix or replace the system since then. A inquiry was made how residents would call for assistance and he stated the aides do rounds every 2 hours and the aides are always close by. A further inquiry was made if the aide checked the resident at 12:00 and they were fine but at 12:30 they in their would they call for assistance to which the Administrator stated I guess they could call out and someone would hear them. Review of the available facility incident reports for and 2015 revealed the following:
a) On at 11:10 a.m. staff heard a resident scream. Resident was found on the floor. Corrective action was 'Resident advised to call for assistance to prevent future '
b) On at 2:45 p.m. a resident was found on the floor by the by staff while doing rounds. Corrective action was 'Resident was advised to be more careful and call staff for assistance.'
c) On at 1:15 p.m. a resident was found on the floor in staff. Corrective action was 'Resident was told to call for assistance.'
d) On at 1:40 p.m. a resident was found on the floor by staff in . Staff observed small laceration on forehead and resident short of breath. Corrective action was 'Resident was advised to call for assistance.'
e) On at 5:00 a.m. a resident was found on floor of staff doing rounds. Corrective action was 'Resident advised to be careful and to call staff for assistance.'

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SUMMARY STATEMENT OF DEFICIENCIES
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0030 Continued From page 4

Review of the facility Incident Report dated at 12AM documented 'Resident #1 was in the wheelchair, the staff found her on the floor of the lobby. Laceration to right hand.' The corrective measure/intervention documented 'Staff will monitor resident more frequently to prevent accidents.'

Review of the Resident Observation Log for Resident #1 revealed documentation dated at 12:00 a.m. the resident was found on the floor in the lobby, the right hand cut and . The resident was sent to the hospital for evaluation of the right hand laceration. Further review of the record revealed no evidence of documentation of how the resident came to be in the lobby in her wheelchair at midnight.

Review of the ALF Rounds sheet dated the aide documented every 2 hour checks of Resident #1 from midnight to 6AM, however at some point the resident was not in the facility as she was sent to the hospital for evaluation. Review of the Resident Observation Log does not document the time the resident returned to the facility from the hospital.

Review of Resident #4's Resident Observation Log documents an admission assessment dated at 6:15 p.m. Documentation on at 11:05 p.m. documents the resident was found on the floor in the lobby. He was found on the floor in the lobby again at 11:20 p.m. and was sent to the hospital for evaluation with a return to the facility at 3:00 a.m. On at 4:00 a.m. documentation states the resident slid, found lying across bed and kicking sliding door; Resident slid out of bed and was helped back in. On at 4:30 a.m. the resident slid out of bed and helped into wheelchair again. On at 6:30 a.m. the resident slid out of bed and helped into wheelchair.

Review of the ALF Rounds sheet for Resident #4 revealed on the 6PM, 8PM and 10PM rounds checks are not documented. The 12AM and 2AM checks document the resident was in the hospital. The 4AM and 6AM rounds checks are not documented. Additionally, the ALF Rounds sheet for Resident #4 revealed on the 8AM, 10AM, 12PM and 2PM rounds checks are not documented.

Review of the facility Staffing Schedules from through reveal on the 11PM to 7AM shift there are only 3 aides staffing a facility with a capacity of 105 residents and a current census on of 93 residents. By that would be one aide responsible for 31 residents. It is also noted on and 15 there were only 2 aides staffing the facility on the 11PM to 7AM shift. By that would be one aide responsible for 46 residents and the other aide responsible for 47 residents.

Random confidential interviews conducted on revealed the following.

a) On at 9:40 a.m. an interview was conducted with the {confidential resident interview}. An attempt was made to use the call bell system to which they responded that doesn't work. An inquiry was made what they would do if they needed assistance and they stated they are pretty independent but could call out if need be.

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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0030 Continued From page 5

b) On at 9:52 a.m. two residents sitting at the end of the 100's hallway were interviewed. An inquiry was made if they needed assistance during the night how would they call for help to which they responded 'you just have to yell loud for someone to hear you.'

c) On at 9:58 a.m. an interview was conducted with the {confidential resident interview}. An attempt was made to use the call bell system to which they responded that doesn't work. One resident stated she has been living here about 3 months and it has not worked since she moved in. She stated if you need to get someone's attention you have to yell.

d) On at 10:01 a.m. an interview was conducted with a {confidential resident interview} and an inquiry was made about the call bell system to which he responded they are not working. An inquiry was made what he would do to call for assistance to which he responded, it's not easy but I would have to transfer myself to the wheelchair and go out to the nursing station if there was anyone there.

e) On at 10:06 a.m. an interview was conducted with the {confidential resident interview} inquiring about the call light system to which they responded the call system does not work. One resident said 'I saved her life' pointing to her who was observed to have on. The resident stated they have both had in the past and her was not doing well so she had to transfer herself into her wheelchair and go out to the nursing station to get help. She stated they called 911 and when the paramedics arrived her was doing very poorly and the paramedics told her if she hadn't called when she did her would have She stated it was very scary and if her was alone she would not have made it. She stated you always hear screaming for help at night. She stated the State came in and they fixed it and then it broke again and has not been working for the past 3 or 4 months.

f) On at 10:23 a.m. an interview was conducted with a {confidential resident interview} who stated the call lights have not worked for a long time now. He stated if you need something at night you yell and hope someone hears you.

g) On at 10:28 a.m. an interview was conducted with a{confidential resident interview}. An inquiry was made how she would get assistance if she needed it and she stated the call bells don't work but she has a cell phone that she could use to call for assistance.

h) On at 11:23 a.m. an interview was conducted with a {confidential resident interview}, asking her what she would do if she needed something at night. She stated she has to use her mouth and call out loud. She stated she has to wait a long time because the call bell has not worked for a long time and the aides get busy with other residents. She stated you hear people yelling and calling all night to get the aides attention if they need help at night.

Class III

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0093 Continued From page 6

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on interview and record review, the facility failed to have a weekly menu for the breakfast meal to identify what foods were being offered at breakfast on a daily basis.
The Findings Include:
On _____ at 9:40 a.m., an interview was conducted with a resident on the 100's hallway who stated the food is satisfactory however breakfast is the same day after day. She stated there are a lot of eggs and no meat offered.
On _____ at 9:45 a.m., an interview was conducted with another resident on the 100's hallway who stated breakfast is the worst, there is no variety and no fresh fruit.
On _____ at 9:58 a.m., an interview was conducted with 2 residents on the 300's hallway, in their both stating breakfast is not great, there are no choices and it is the same every day, eggs and bread. They stated it would be nice to change it up.
On _____ at 10:01 a.m., an interview was conducted with a resident on the 300's hallway who stated breakfast is the worst, they serve eggs everyday and it is not healthy to eat eggs on a daily basis. He stated it would be nice to have fresh fruit once in a while.
On _____ at 10:06 a.m., an interview was conducted with a resident on the 200's hallway who stated breakfast is terrible, they serve egg substitute during the week and have real eggs only on the weekends. She stated everyday it is an egg and a bagel, rarely do we get french toast or waffles to change it up a bit. She stated if they serve meat you are lucky if you get one slice of bacon.
On _____ at 10:23 a.m., an interview was conducted with a resident on the 200's hallway who stated the food is terrible. He stated breakfast is not good, there is no variety, no choices and no meat. He stated you don't have to have meat everyday but once in a while would be nice.
Review of the facility's 4 week menu cycle prepared by the Registered Dietician with an effective date of _____ and expiry date of , revealed all the breakfast items were documented under the Sunday column with no indication of what was to be served on that day. Further review of the Monday through Saturday menus for breakfast for the 4 menu cycles revealed they were blank.
On _____ at 3:30 p.m., an interview was conducted with the Administrator who stated they alternate between bacon and sausage for breakfast and they have bagels, french toast and waffles alternating. The 4 cycle menus were reviewed with the Administrator at this time and he confirmed there was no meat listed on breakfast menu. On _____ at 4:30 p.m. the Administrator stated he has spoken to the Registered Dietician and she will revise the menu to reflect the breakfast menu for each day of the 4 cycle menus.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

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

RE: CCR #2014012300 & CCR #2015000021

Dear Administrator:

This letter reports the findings of complaint surveys that were conducted on 16, 2015, , 2015 and , 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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