STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953535	**06/26/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD HOPE MANOR	**2251 NW 29TH COURT OAKLAND PARK, FL 33311**	

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

0000 - Initial Comments

An unannounced Relicensure survey with Limited Nursing Services (LNS) was conducted on [redacted] through [redacted] and [redacted] at Good Hope Manor. The facility had deficiencies found at the time of the visit.

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

Based on interview, record review and observation, the assisted living facility (ALF) failed to have an adequate 3-day emergency supply of nonperishable food for a resident census of 80.

The findings include:

On [redacted] at approximately 10:15 AM, observations found the ALF did not follow their emergency disaster plan menu for all items listed. Observations found the facility does not have an adequate 3- day emergency supply of nonperishable food as evidenced by lack of 2 cases of 6 cans of beef stew and 2 cases of 6 cans of ravioli.

On [redacted] at 12 PM, a facility record review of the disaster menu inventory sheet lists food items and amounts. The facility's disaster menu inventory sheet was [redacted] and approved by a registered dietitian on [redacted] The sheet indicates Beef Stew: 2 cases of 6 and Ravioli: 2 case of 6 (Copy obtained).

In an interview on [redacted] at approximately 11:30 AM with the Food Service Manager, she stated she was using the cans of ravioli and beef stew for daily use and has to re-order those items for emergency supply.

During an interview on [redacted] at approximately 12 PM, the Administrator and the Director of Nursing acknowledged the findings.

Class III

N277 - LNS - Resident Care Standards - 58A-5.031(2) FAC

Based on observation, interview and record review the facility failed to adequately monitor and assess 1 of 1 residents, Resident #1, reviewed under Limited Nursing Services (LNS) related to [redacted] care for Resident #1.

The findings include:

On [redacted] at 9:35 AM an interview was conducted with the Assisted Living Facility (ALF) Administrator who stated they only have 1 resident under LNS, Resident #1, for the care and monitoring of a [redacted] On [redacted] at 9:40 AM Resident #1's [redacted] observed in the presence of the Administrator. The [redacted] observed to have splatters of yellowish brown matter on the toilet, walls and floors. The Administrator could not explain or identify what this matter was. An inquiry was made to the Administrator where they keep the

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resident's drainage bag she uses at bedtime and she stated it is kept under the . Opening the door revealed the drainage bag was sitting directly on the floor of the cabinet, with still in the bag and the connection tip of the tubing not covered which is an control hazard as the tip of the drainage tubing is connected to the tubing of the and the tubing goes into the resident's .

On at 9:45 AM an interview was conducted with Resident #1 inquiring about the to which she replied it does not feel comfortable. An inquiry was made if she was having any pain related to the and she stated 'yes.' Pain or discomfort is not a usual occurrence related to a and could be indicative of an process. The drainage bag could not be observed at this time as it was covered by her pant leg.

On at 10:00 AM an interview was conducted with the Advanced Registered Nurse Practitioner (ARNP) who also is the LNS Supervisor what services they provide to Resident #1 under LNS to which she responded they observe for any signs and symptoms of and make sure the is intact. She stated the drainage bags are changed from the large one at bedtime to a leg bag during the day so the resident is observed twice a day either by her or the Registered Nurse who is also on staff.

On at 10:25 AM another tour was conducted with the ARNP to observe Resident #1's . The splattered matter had been attended to. An inquiry was made to the ARNP where the evening drainage bag is stored and she proceeded to open the cupboard door to reveal the drainage bag was now in a wash basin with the observed in the bag earlier had been disposed of but the drainage tubing continued not to have a protective cover or cap covering the end of the tubing that connects to the This was brought to the attention of the ARNP who proceeded to retrieve the drainage bag with her bare hands and threw it in the garbage stating she will get a new bag. She then proceeded to exit the washing her hands, went back downstairs to the nursing office and spoke on her cell phone still without washing her hands after disposing of the used drainage bag.

On at 10:30 AM Resident #1 was brought into the nursing station and a request was made to observe the drainage leg bag with her consent. The ARNP proceeded to pull up the resident's pant leg to reveal the leg bad attached to her right leg. The in the bag was dark amber in color and looked concentrated. This was brought to the attention of the ARNP who stated to the resident she has to drink more fluids. The ARNP pulled the resident's pant leg back down and still had not washed her hands.

Review of the clinical record for Resident #1 revealed she was admitted to the ALF on from a hospital stay with a diagnosis to include retention requiring a . Review of the hospital notes dated documents the urinalysis done at the hospital, while the resident had the was negative for or .

Review of the admission Progress Notes dated documents the resident has a . Review of the LNS Nursing Progress Notes dated documents the LNS service to be 'Monitor the placement and

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will continue to monitor. Review of a Physician Verification Form dated documents 'LNS to monitor placement and functioning of There is no evidence of documentation of a baseline assessment of the status of the and drainage.
Further review of the Progress Notes and LNS Notes reveal no other evidence of documentation of the status/assessment/monitoring of the until an entry in the Progress Notes dated at 2 PM documenting 'Resident noted large amount of in Transfer to (name of hospital)'. The resident returned to the facility at 10 PM. Review of the Progress Notes does not document any assessment of the or assessment of the drainage upon the resident's return. Further review of the clinical record revealed a hospital discharge instruction form dated documenting the discharge instructions for a diagnosis of with the treatment being a 7 day course of

Review of LNS Nursing Progress Notes dated documents - Nursing assessment done. No distress. Will continue. There is no documentation of the and no documentation of the treatment of a on

Further review of the Progress Notes reveals the next documentation related to the assessment/monitoring of the dated at 1:05 PM documenting 'Resident complain that her came out. Send to (name of hospital). On at 7:15 PM documentation states 'Return to facility. Her was replaced.' Further review of the clinical record revealed a hospital discharge instruction form dated documenting the discharge instructions for a diagnosis of with the treatment being a 7 day course of

There is no further documentation of any assessments/monitoring of the until the next entry dated at 11:25 AM stating 'Noticed in her Transfer to (name of hospital). On at 8:10 PM the resident returned to the facility with no documentation of any assessment/monitoring of the Further review of the clinical record revealed a hospital discharge instruction form dated documenting the discharge instructions for a diagnosis of with the treatment being used for relief of pain associated with a every 8 hours for 3 days while she was still on a 7 day course of started on Review of the Medication Observation Record revealed the resident was started on the on 3 days after the order from the hospital of

Further review of the Progress Notes dated at 3:45 PM documents the 'resident was sent to the hospital because she had hematuria in in her ' The resident returned to the facility on at 12 AM with no evidence of documentation of the status/assessment of the

Further review of the Progress Notes dated at 2:07 PM documents 'Resident pull her out, the balloon was intact. She has retention. Transfer her to (name of hospital). The resident returned to the facility on at 5:45 PM documenting 'Her was installed' with no evidence of documentation of the status/assessment of the Review of the Medication Observation Record for revealed on the resident was started on 2 new treatments, one for a course of 7 days and the other for a course of 10 days.

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There is no further evidence of documentation in the clinical record or the LNS Progress Notes of the status/assessment/monitoring of the ; the resident's output; tolerance to the 4 different treatments and 1 treatment for the from through ; any other non-medicinal interventions for example increased fluid intake; or any pain assessment related to the requiring a course of for 3 days.

Review of the LNS Care Plan dated on admission documents under 'Goal - Patient remain free from acute complications of the Needs include - Assist with care; encourage oral fluid intake. Follow up/Outcomes - The patient will be able to remain free from any acute process associated with indwelling

On at 12:00 PM an interview was conducted with the ARNP LNS Supervisor who confirmed they have not been routinely documenting the assessment of the for Resident #1 and further stated she thought they only had to document on a monthly basis. It was pointed out that the resident has a and has had 3 in a month with no evidence of documentation of the assessment or monitoring of the or output to which the ARNP LNS Supervisor concurred, had they been documenting more they might have noticed changes before the started. She stated they will document more frequently from this day forward.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Administrator
Good Hope Manor
2251 NW 29th Court
Oakland Park, FL 33311

RE: Relicensure Survey with Limited Nursing Services (LNS)

Dear Administrator:

This letter reports the findings of a Relicensure survey with Limited Nursing Services (LNS) that was conducted on , 2015 through 2015 and , 2015 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. **Please forward documentation of correction to the Field Office.** 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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