STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964612	**06/18/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
MANULY'S ADULT CARE	**12710 NW 8 LANE MIAMI, FL 33182**	

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

0000 - Initial Comments

A Complaint (#2015006011) Survey was conducted on . . . . . Manuly's Adult Care had deficiencies identified at the time of the survey.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28 FS

Based on observations, record review, and interviews, the facility failed to coordinate the delivery of services with hospice for 4 out of 7 (#'s 1, 4, 5, and 7) sampled residents. The facility failed to limit physical to half bed rails with a doctor's order for usage for 2 out of 7 (#'s 4 and 5) residents, the facility used furniture and multiple bed rails as forms of to prevent residents from getting out of the bed. The facility also endangered residents and violated their rights by allowing a non-resident/staff who did not have a Level II background screening to sleep in the facility and to perform personal hygiene and store clothing in resident .

Findings included:

On at 5:30 a.m., Resident #4 was observed being restrained in bed by the use of a recliner placed against the bed alongside of a half bed rail. This prevented the resident from being able to get out of bed without staff assistance.
On at 5:30 a.m., Resident #5 was observed in bed with two sets of half bed rails on the right side of the bed. This prevented the resident from being able to get out of bed without staff assistance. The resident was repeatedly shouting, "Let me out! Get me up!" The staff did not respond to these requests.
On at 5:35 a.m., Resident #3 was observed using a portable toilet in his Resident #2 was present.
On , at 5:30 a.m., Residents #'s 1, 4, 5, and 7 were observed in the facility, bed-bound and unable to assist with activities of daily living (ADLs). Residents #'s 4 and 5 were observed to be unable to use their hands.
Record review revealed, Residents #'s 1,4, 5, and 7 were receiving hospice services. Record review revealed, the facility did not have interdisciplinary plans of care for four of four residents under hospice care (Residents #'s 1, 4, 5, and 7). The facility failed to coordinate with hospice services to have staff perform administration of medications to the four hospice residents.
On at 8:20 a.m., Staff C, who arrived at work at 7:25 a.m., was observed taking a crushed substance that had been left in the medicine cabinet area and pouring it into a hot cup of coffee. Staff C then poured the mixture into Resident #4's mouth. When asked how she knew what she was giving the resident, Staff C stated that Staff B had told her what it was.
On , Staff #C stated, regarding Resident #4, "This is the only way this resident can take her medication because she can't do it herself. She can't even hold the cup, and it is hard for her to swallow. She likes coffee so someone figured out to put the meds in there."
Record review on revealed, that the Agency for Health Care Administration (AHCA) Form 1823 Health Assessment for Residents #4 and 5 stated that the residents were able to self-administer their medications. The Health Assessments were not updated to reflect that the residents needed administration of medications. A review of Resident #4's record revealed that there was no doctor's order for the resident's medications to be crushed

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before they were administered.

On at 5:47 a.m., a woman who identified herself as the "sister" of Staff B was observed brushing her and using the a resident . She also was observed going into a portable closet inside Residents #6 and 7's . The portable closet in the resident's filled with the "sister's" clothing.
On record review revealed that the woman observed in the facility was living with a census of seven residents and having access to the resident area and sharing space with residents and did not have a record at the facility and did not have level II background screening or any documentation of training regarding or neglect of the elderly.

Class II

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on record review and interview, the facility failed to ensure that the Manager did not supervise any other facilities.

Findings included:

On at 7:25 a.m., Staff B stated the facility's Administrator was out of the country and the facility's Manager was taking care of another facility and that was the reason she could not come to facility.

Phone interview on at 7:50 a.m. with the Administrator, he stated, he was 12 hours from facility, in another country.

Record review showed the facility's Administrator supervised three facilities. The facility's appointed Manager was the Administrator at another facility.

Class III

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

Based on observation, record review, and interview, the facility failed to ensure in the absence of the Administrator, qualified staff was responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents. The facility had 7 residents living at the facility. The facility also did not have a staff member designated in writing to be in charge of the facility when the facility administrator and/or manager were absent.

Findings included:

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Upon arrival at the facility on at 5:15 a.m., and knocking and calling for at least 5 minutes, without being able to reach anyone inside of the facility, furniture was heard moving inside the facility. A staff member finally came to the door and asked for a moment before she opened the door.
On at 5:25 a.m., observed Staff B and another woman in the facility with 7 residents. On at 5:30 a.m., Residents #'s 1, 4, 5, and 7 were observed in the facility, bed-bound and unable to assist with activities of daily living (ADL's). Residents #'s 4 and 5 were observed to be unable to use their hands. Staff C arrived on at 7:25 a.m., but did not stay for the survey.

Reviewe of the staff schedule for 2015 (third week) documented the following for Thursday,
7 am to 4 pm, Staff B (present during the survey)
7 am to 3 pm, Staff C (arrived at 7:30 am and left during the survey)
12 pm to 8 pm, Staff A (not present during the survey)
8 pm to 7 am, administrator (not present during the survey)

The facility is required to have 212 hours per week for a census of seven residents. During the monitoring survey on it was revealed, the facility did not have a person in charge in the absence of the Administrator. The designated Manager was unable to communicate with the surveyors during the survey because she had an unlicensed investigation in progress at another location. Record review showed, the facility did not have a staff member designated in writing to be in charge of facility during the absence of the Administrator and Manager's absence.

On at 7:25 a.m., Staff B stated the facility's Administrator was out of the country and the facility's Manager was taking care of another facility and this was the reason she could not come to the facility.

On at 6:30 a.m., unidentified medications were observed in cups in the medicine cabinet area. Staff B stated, she prepared the medications during the night and signs the medication observation records (MOR's) in advance because she does not have time to do these tasks in the morning.

MORs were reviewed on at 5:50 a.m., they showed 6 out of 7 residents (#'s 1, #2, #4, #5, #6, #7) medications were signed as given on for 7:00 a.m. (scheduled dosage time).

Medication pass observations on at 6:35 a.m. found the following:
Staff B took the medications that were already placed in a cup from the medication cabinet for Resident #1. She dropped the medications on a spoon then gave the medications to Resident #1.

On at 7:20 a.m. Staff B took the medications already placed in a cup from the medication cabinet. Staff B dropped the medications in a napkin that was on the table, she asked Resident #2 if he was going to take the medications. Resident #2 answered, "I will take it later," while eating breakfast. Staff B left the residents and did not observe or ensure that Resident #2 took his medications.

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On , at 7:35 a.m., Staff B took medications already placed in a cup from the cabinet where day care participant medications were stored. Staff B dropped Resident #3's medications on a spoon then gave the medications to the resident.

Staff B stated, this was a day care resident and the facility did not have the MOR's for Resident #3.

On , at 8:20 a.m. Staff C, who arrived at work at 7:25 a.m., was observed taking a crushed substance that had been left in the medicine cabinet area and pouring it into a hot cup of coffee. Staff C then poured the mixture into Resident #4's mouth. When asked how she knew what she was giving the resident, Staff C stated that Staff B had told her what it was.
On , Staff #C stated regarding Resident #4, "This is the only way this resident can take her medication because she can't do it herself. She can't even hold the cup, and it is hard for her to swallow. She likes coffee so someone figured out to put the meds in there."
Record review on revealed that Agency for Health Care Administration (AHCA) Form 1823 Health Assessment for Residents #4 stated that the resident was able to self-administer their medications. The Health Assessment was not updated to reflect that the resident needed administration of medications. A review of Resident #4' s record revealed, there was no doctor's order for the resident's medications to be crushed before they were administered.

On , a Agency for Health Care Administrator requested a directed plan of correction from the facility. The directed corrective actions included:

1. The Assisted Living Facility is required to submit a plan to the Agency by 5:00 PM on , 2015, indicating how the facility will come into compliance with the facility's licensed capacity of six beds
2. The Assisted Living Facility is required to submit a staffing schedule by 5:00 PM on , 2015 detailing which qualified staff will be available to provide care and services through , 2015.
3. The Assisted Living Facility is required to provide written documentation of a qualified manager or designee providing oversight to the field office in the absence of the administrator to the Area 11 field office by 5:00 PM 19, 2015.
4. The Assisted Living Facility is required to provide a written plan outlining the facility's actions to ensure the provision of three meals a days plus a snack with less than 14 hours between dinner and breakfast.

As of , AHCA has not received any documentation from the facility.

Class II

Z827 - Unlicensed Activity - 408.812, FS

Based on observations, record review, and interview, the facility failed to obtain a licensure capacity increase prior

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Z827 Continued From page 4

to providing personal care, meals, and assistance with medications to seven residents. The facility provided services to residents outside the current license capacity of six.

Findings included:

Upon arrival to the facility on at 5:15 a.m. and after knocking and calling for at least 5 minutes without being able to reach anyone inside of the facility, furniture was heard moving inside the facility. The staff member finally came to the door and asked for a moment before she opened the door.
On at 5:25 a.m., observed Staff B and another woman in facility with 7 residents. On , at 5:30 a.m., Residents #s 1, 4, 5, and 7 were observed in the facility, bed-bound and unable to assist with activities of daily living (ADLs). Residents #s 4 and 5 were observed to be unable to use their hands.

Facility tour on at 5:25 a.m. with Staff B found the following:
, Residents #'s 4 and 5
#_, Resident #1
, Resident #'s 3 and #2
, Resident #'s 6 and #7

Record review of the facility's admission and discharge log documented the following residents were admitted to facility:
Resident #,1 Admitted: /
Resident #2, Admitted:
Resident #4, Admitted: /
Resident #5, Admitted:
Resident #6, Admitted /
Resident #7, Admitted:

Record review also showed Residents #s 1, 2, 4, 5, 6, and 7 had resident agreements executed between the residents and the facility. Resident #3 (admitted on) had a day care agreement with the facility from 7 a.m. to 8 p.m. The day care agreement showed Resident #3 would receive three meals per day and would not receive housing and a resting area.

On at 5:25 a.m. Staff B stated the facility had 6 residents and Resident #3 was a day care that slept in the facility when her son could not take care of the resident.

On at 6:50 a.m. Resident #3 stated, she was living in facility for several months.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Manuly's Adult Care
12710 Nw 8 Lane
Miami, FL 33182

RE: CCR #2015006011

Dear Administrator:

This letter reports the findings of a Complaint survey that was conducted on , 2015 by representative(s) 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 surveyor(s). Should you have any questions please call Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure
XG90

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