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	AL11910722	**09/10/2015**
NAME OF PROVIDER OR SUPPLIER **LAUDERHILL MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **2801 NW 55TH AVENUE LAUDERHILL, FL 33313**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 Initial Comments

An unannounced Assisted Living Facility Relicensure survey was conducted on 9/9/15, 9/10/15 at Lauderhill Manor. The facility had deficiencies found at the time of the visit.

This survey was conducted in conjunction with Licensure complaints, (CCR #2015005977, CCR #2015006759 and CCR #2015007568). Please refer to seperate report for findings.

0008 Admissions - Health Assessment

Based on record review and interview, the facility failed to ensure resident records contain documentation of a completed medical examination recorded on a Resident Health Assessment (AHCA Form 1823), which was completed 60 days prior to admission or 30 days after admission, for 1 of 3 residents reviewed (Resident #30)

The findings include:

A review of Resident #30's record revealed a contract for admission and financial agreement dated , signed by the resident's daughter and responsible party. A review of the facility's admission and discharge log reveals that Resident #30 was admitted to the facility on . A review of Resident # 30 record revealed a progress note dated / / at 3:00 PM shows that the resident was admitted on / / , assessed and was familiarized with facility policies. Further review of Resident #30's record revealed an AHCA Form 1823 dated / , approximately 5 months prior to admission.

During an interview conducted with the Assistant Administrator on / at 11:10 AM, he confirmed that there was no other AHCA Form 1823 available for review. In an interview conducted with the Administrator on / / at 1:15 PM he confirmed the findings.

Class III

0010 Admissions - Continued Residency

Based on observation, interview and record review, the facility failed to ensure that a resident's Health Assessment Form (AHCA Form 1823) was accurate and reflective of their current care needs and services, for 3 out of 3 residents' records reviewed (Resident #1, # 2 and #14).

The findings include:

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1) On 9/9/2015, a record review of Resident # 1's AHCA Form 1823 revealed an admission date of 10/20/2014. Resident #1's medical exam dated for documented the following diagnosis: , , Dyslipidemia, , , , and . Resident # 1's file revealed a Hospice Integrated Plan of Care dated for / and is signed by the Hospice Vitas staff and the ALF Administrator of Lauderhill Manor. Resident # 1's Hospice Interdisciplinary Care Plan is on file and completed monthly. Resident # 1's Hospice evaluation was found on file with a start date of and a diagnosis of . Observations on the morning of / found the Hospice RN in the facility to visit Resident # 1. Further record review of Resident # 1's file found no new AHCA Form 1823 since her admission to Hospice indicating the significant change in health status and diagnosis.

2) A record review of Resident #2 revealed an admission date of . Resident # 2's AHCA Form 1823 assessment was completed on with a diagnosis of chronic pain, scoliosis, , overactive , incontinence, and . The AHCA Form 1823 assessment states Resident # 2 uses a walker to ambulate (Copy obtained). Observations and interviews with Resident # 2 on revealed Resident # 2 uses a wheelchair to ambulate. Further review of the AHCA Form 1823 assessment indicates that Resident # 2 is at risk for . The AHCA Form 1823 assessment indicates that Resident # 2 requires assistance with ambulation, bathing and is independent with transferring. In an interview conducted with Resident # 2 on , she stated she needs assistance while transferring from bed to wheelchair or from wheelchair to bed. A review of Resident # 2's incident report dated for indicates staff reminds Resident # 2 to wait for help when she needs to transfer. Further review of Resident # 2's AHCA Form 1823 assessment revealed that it is not reflective and consistent with her current care needs. Further record review revealed no further documentation regarding aforementioned information to reflect the current ADLs for the resident.

During an interview with the Administrator on at 4:50 PM, the Administrator reviewed the AHCA Form 1823 assessments for Resident #1 and #2. He acknowledged the findings of Resident #1 and #2 requiring updated assessments regarding ADL status and significant changes in condition. He stated no further documents were available for review.

3) Resident #14 was initially admitted to the facility on with diagnoses to include muscular , ataxia (the loss of full control of bodily movements), and sleep . Resident #14 ' s Resident Health Assessment for Assisted Living Facilities (AHCA Form 1823) dated was reviewed and revealed the following; the section titled Nursing/treatment/ service requirements the only entry was N/A (not applicable). The Resident was noted as independent for ambulation, eating, self-care, , toileting, and transferring. This was in conflict with information entered on a supplemental untitled facility form which indicates that the Resident performs the tasks of hygiene and dressing with assistance. The comments section of this form indicates that Resident #14 uses a walker and scooter as needed. There is no mention of a wheelchair on either form. On page 2 of

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the 1823 form, Section B titled " Special Diet Instructions " , a regular diet was marked. The section titled " other, please describe " was blank.
Further review of Resident #14's records revealed that during a visit to a family member's home the Resident and her leg. The Resident was admitted to a rehabilitation facility where she improved to her projected functional level and was discharged back to the facility on . The Resident ' s rehabilitation discharge instructions were reviewed and included orders for a wheelchair with removable arms to be provided by a HHA. The discharge instructions further note that the Resident is to be on a regular mechanical soft diet with thin liquids. On / a wheelchair was ordered for the Resident by a home health agency; none of these changes precipitated by the significant change of a requiring transfer to a higher level of care were reflected in the Resident ' s current 1823 form, with no updates having been made since the form was completed on .
During a observation of Resident #14, the Resident was noted to be seated in a wheelchair.
During a / observation of the Resident in her , the Resident was served a meal tray which contained bone-in barbecued chicken and cooked greens that had not been cut or chopped. The resident confirmed that she was not being served a mechanical soft diet and stated that she either asked someone to cut her food or did not eat the food, instead eating items she had purchased herself. Resident #14 further confirmed that she sometimes coughs when swallowing.
Record review of Resident #14 hospice folder, which contained an health care provider order to admit Resident #14 to hospice. On the same order was an order for the Resident to receive a mechanical soft diet with thick liquids. During a subsequent interview with the facility Assistant Administrator (AA), the AA confirmed that the facility was unaware of the order for Resident #14 to receive a mechanical soft diet. The surveyor noted that the Resident is not included on the list of resident receiving hospice services provided by the facility on . The significant change in condition of Resident #14 after readmission from the rehabilitation facility and being admitted to hospice services was not reflected on the Resident ' s current 1823 form, with no updates having been made since the form was originally completed on / . The facility was unable to produce an interdisciplinary care plan between the facility and the hospice agency at the time of the survey.

Class III

0025 Resident Care - Supervision

Based on observation, record review, and interview, it was determined that the facility failed to provide the necessary care and supervision for 1 of 6 residents reviewed for quality of care and services . A newly admitted resident (Resident # 25) received no glucose checks, sliding scale administration, or care for three days despite a physician ' s order to provide these services. Furthermore, the facility did not provide adequate supervision to prevent unnecessary for one of three residents (Resident #2) reviewed for precautions.

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The findings include:
1) On 09/09/2015 a review of Resident # 25 ' s Resident Health Assessment for Assisted Living Facilities form and facility admission records revealed the following:
Resident # 25 was admitted to the facility on / at 5:00 PM. The Resident was admitted to the assisted living facility from a rehabilitation facility, with diagnoses to include Type II , wounds to and lower back, and a non-healing to the right lower extremity. A facility form dated / and titled Facility Admission Note has the following entry in the section titled ' Skin ' : " on and on Lt (left) leg both legs and (illegible). " The form also indicates that the Resident ambulates with a wheelchair, has moderate vision problems, and requires assistance with dressing and hygiene.
Resident # 25 ' s Resident Health Assessment for Assisted Living Facilities form was reviewed and revealed the following:
a) In the section titled Medical history and diagnoses on page 1 of the form were the following entries- Type II ; ( ), ( ), wounds to and lower back, non-healing . (right) lower extremity.
b) In the section titled Nursing/treatment/ service requirements on Page 1 of the form were the following entries- ADL (activities of daily living) care, care, medication administration.
c) On page two of the form the Resident is listed as requiring assistance with ambulation, bathing, dressing, , toileting, and transferring. On page two, section C, question 3 of the form the question" Does the Resident have any of the following conditions: , 3, or 4 pressure sores is answered Yes.
d) In the section titled " Does the Resident need help with his/her medications " On Page 4, Section B of the form, the question ' Does the individual need help with taking his or her medication? ' was answered YES. In the same section, the box titled ' Needs Medication Administration ' is checked. This entry is inconsistent with page 1 of the form, which also indicates medication administration is required.
e) The Medications section of the same form on page 4 lists 21 medications prescribed for Resident #25. Among the medications prescribed are injections once daily and glucose checks with humulog pen administration per sliding scale before meals and at bedtime.
Review of Resident observation logs showed the following:
a) / at 5:00 PM:" Resident admitted to the facility today from (nursing and rehabilitation facility), Resident is alert and responsive, he is a (race)male, (age) years old, weight XX pounds, Resident will need assistant WC (wheelchair) transporting and showering. Noted Resident have both feet with and bandage, also to buttox. Resident uses a wheelchair, came in with prescription which (was) filled by the facility at (name of pharmacy), patient is getting settled at this time. Placed in (#) with belongings. Resident suffers from ( ), ( ), type 2 .
b) There is no entry on the Resident Observation log for the date of .
c) On an 11:00 AM entry notes the following; "(Home Health Agency name) RN (registered

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nurse) came to the facility to evaluate and admit the resident. Resident is out of the facility at this moment. RN stated that the facility should call agency when Resident returns".
The next entry on the facility Resident Observation Log was made at 7:00 PM and reads as follows- "Resident came back to the facility. He states that he was out doing errands. Staff advised resident to stay at the facility, that the home health will come to visit him and start service for his wounds. Adm (administrator) notified".
There is no documentation that the Home Health Agency was called to return or ever saw the Resident. There is no documentation of any care being provided during Resident #25 ' s stay at the facility.
During a 3:45 PM interview with the facility ' s Assistant Administrator (AA), the AA confirmed that the Resident was never seen by the Home Health Agency nurse or the Limited Nursing Services nurse, and that care was not provided for the Resident. When asked by the surveyor how facility personnel had determined that they were able to provide the needed level of care for Resident # 25 prior to admitting the Resident, the AA responded that the facility staff were unaware of Resident #25 ' s need for care " until he got here " .
During a 3:20 PM telephone interview with the Director of Nursing (DON) at the rehabilitation facility from which the Resident was transferred, the DON stated that the Resident had a with bright red bloody drainage on the left , as well as multiple on his legs at the time of discharge to Lauderhill Manor. The DON further stated that her facility had made arrangements for a Home Health Agency to see the Resident upon transfer to Lauderhill Manor in order to provide care for the Resident.
A / health care provider order for Resident #25 reads as follows- " care eval (evaluation) transfer to (name of hospital) due to /3 - lower extremity "
The Resident ' s medication record further lists humulog per sliding scale. On the area of the form where the dates of medication assistance and the initials of the mediation technician are documented, ' HHA " (home health agency) is written in large letters.
The surveyor was unable to locate any documentation that the Resident ever received any glucose monitoring or administration during his stay at the facility, despite health care provider orders to do so. A / telephone interview with staff of the HHA named in the Resident ' s facility records confirmed that the HHA never saw or provided any sort of care to the Resident during his stay at the facility. During a / interview with the facility ' s Assistant Administrator (AA), the AA confirmed that the facility had not assured that the facility records contain documentation of any follow-up efforts to assure that the Resident was provided the care and services ordered by the health care provider on the Resident's 1823.

2) A record review of Resident # 2 revealed an admission date of . Resident # 2's AHCA Form 1823 assessment was completed on with a diagnosis of chronic pain, scoliosis, , overactive , incontinence, and . The AHCA Form 1823 assessment states

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Resident # 2 uses a walker to ambulate (Copy obtained). Observations and interviews with Resident # 2 on 9/9/2015 revealed Resident # 2 uses a wheelchair to ambulate. Further review of the AHCA Form 1823 assessment indicates that Resident # 2 is at risk for . The AHCA Form 1823 assessment indicates that Resident # 2 requires assistance with ambulation, bathing and is independent with transferring. In an interview conducted with Resident # 2 on , she stated she needs assistance while transferring from bed to wheelchair or from wheelchair to bed. A review of Resident # 2's incident report dated for indicates staff reminds Resident # 2 to wait for help when she needs to transfer.

A record review of the facility's incident log revealed Resident # 2 had a on at 6:15 PM in her . The incident report states that Resident # 2 stated that when staff put her in bed, she got up to go to smoke and she . The report states the accident was non- fatal and Resident # 2 on her back. Emergency treatment that was given was transfer to the hospital. The steps taken to prevent recurrence were staff reminded Resident # 2 to wait for help when needing to transfer. Resident # 2's family and Physician were notified. A Progress note dated for at 6:45 PM states that Resident # 2 called the paramedics herself when she on . The paramedics came to the nurse's station stating that they got a call from Resident # 2 in (#). When staff and the paramedics went to the saw Resident # 2 on the floor (copy obtained). Further review of Resident # 2's progress notes document that on , Resident # 2 complained of pain in her back because she earlier that morning. On , Resident # 2 was transferred to the hospital. Progress note dated for at 11:45 am, states that staff found Resident # 2 laying on the floor in her (copy obtained). Resident # 2 stated she from her wheelchair but refused to go the hospital. The Administrator was notified.

In an interview conducted on at 10:55 am with Resident # 2, she stated a staff member will conduct a once in the morning, once in the afternoon, and once in the evening. Resident # 2 stated it is very difficult and sometimes impossible to call for assistance. She stated there is a call bell system in her does work. Resident # 2 stated, she has to yell for help and most of time staff does not hear her. She stated she needs assistance with transferring and she cannot get help. She stated on the day she on in the evening, she yelled for help and staff did not show up, so she had to transfer herself from the bed to the wheelchair and she while transferring.

Observations of Resident # 2 at 11:05 AM, found her yelling for help to get to the lobby. Observations revealed it was impossible for staff to hear Resident # 2 yell because she cannot yell very loud. Observations at 11:14 AM found Resident # 2 helping herself in her wheelchair and going down the hallway. In an interview with Resident # 5 on at 11:15 am, she revealed staff does not respond to Resident # 2 when she yells for assistance most of the time. Resident # 5 stated staff cannot hear Resident # 2 and at times she will try to get staff's attention for Resident # 2.

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Observations on 9/9/2015 found 5 Certified Nurse Assistants on the 6:30 a - 3 p work shift. On 9/9/2015 at 1:40 PM, observations found Resident # 5 at the facility's front desk requesting help for Resident # 2. Resident # 5 stated to the state surveyor that Resident # 2 is in bed and yelled for help, but no one came. She stated Resident # 2 asked her for help to get out of bed, but she stated she has a bad back and she would go to the front desk to her some help.

On at 11:30 AM, Staff A stated the facility has no system for the residents to call for assistance. She stated the residents have to yell for help and if staff hear them they will go to the resident immediately. She stated the direct care staff conduct every 2 hours.

On / at 9:55 AM, Staff B stated while she is working on the 6:30 AM through PM shift, she conducts every 2 hours. Staff B stated if a resident has an incident in their require assistance in their between ; the resident has to yell for help. Staff B stated if she hears the resident yell out she will assist them immediately, but if she does not hear a resident yell out or if a resident has or passed out in their between ; staff are not made aware until they are conducting . Staff B stated the facility usually has a total of 5 direct care staff members which includes a Med Tech providing direct care to all residents.

On at 4:45 PM, an interview with the ALF Administrator. He stated, direct care staff conduct on residents every two hours. He stated he has a log that employees use to sign off after they have completed (Copy obtained). He stated when Resident # 2 , a staff member put her in her bed and a few minutes later she got out of bed to go outside to smoke and during transferring herself. He stated he has no system for residents to use when residents require assistance in between the times of . He stated a resident would have to yell or try to get to the front desk for assistance. He stated if a resident yells out for help and staff does not hear them, the resident will have to wait until staff conduct the next . He stated if a resident requires assistance with transferring or ambulation they will have to yell for help or just wait until a staff member is conducting . The surveyor asked the Administrator, "If a resident has a in their between the hours of and unable to yell for help, how do they get immediate attention?" The Administrator stated he has enough staff working in the facility to conduct , but if an incident occurs with a resident while staff is not present, he cannot do anything about it.

On at 6 PM, the ALF Administrator reviewed Resident # 2's files and assessments and acknowledged the findings. He stated no further information was available for review.

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0052 Medication - Assistance with Self-Admin

Based on record observations and interview, it was determined that the facility staff failed to follow the appropriate procedures when assisting a resident with his/her self-administered medications, for 3 out 9 residents observed (Resident #21, #22 & #23).
The findings include:
During an 12 PM observation of Staff #A assisting residents with self-administration of medications (a process also known as med pass), the surveyor observed the following:
a) Medication Technician #A sanitized her hands and proceeded to remove a several pharmacy prepared single dose medication cards for Resident #21 from a drawer in the medication cart. Staff #A then took two cards to the dining where Resident #21 was seated, and proceeded to identify each medication to the Resident as 50 mg 1 tablet and 100 mg 1 tablet were popped from the pharmacy card into a paper cup. Staff #A then observed Resident #21 swallow the medications and then returned to the medication cart, located the Resident ' s MOR in a large three ring binder, and marked the medications as taken. At no time prior to taking the medications to Resident # 21 did Staff #A check the MOR to verify that there had been no changes in the Resident ' s medication orders and that she(Staff #A) was assisting the Resident with the correct medications, thereby placing the Resident at potential risk for a medication error.
b) Staff #A sanitized her hands and then took several pharmacy prepared single dose cards for Resident #22 from the medication cart drawer. Staff #A then took two cards to the Resident, who was seated at the dining , and proceeded to identify each medication to the Resident as 100 mg 1 tablet and Cardopa/levo 2 tablets were popped from the pharmacy card into a paper cup by staff #A. Staff #A observed Resident #22 swallow the medications and then returned to the medication cart, located the Resident ' s MOR in a large three ring binder, and marked the medications as taken. At no time prior to taking the medications to Resident # 22 did Staff #A check the MOR to verify that there had been no changes in the Resident ' s medication orders and that she(Staff #A) was assisting the Resident with the correct medications, thereby placing the Resident at potential risk for a medication error.
c) Staff # A then proceeded to sanitize her hands and remove a single pharmacy prepared single dose medication card for Resident #23 from a drawer in the medication cart. Staff #A then took the card to the Resident, who was seated at the dining , and proceeded to identify the medication to the Resident as 300 mg 3 tablets were popped from the pharmacy card into a paper cup by staff #A. Staff #A observed Resident #23 swallow the medication and then returned to the medication cart, located the Resident ' s MOR in a large three ring binder, and marked the medications as taken. At no time prior to taking the medications to Resident # 23 did Staff #A check the MOR to verify that there had been no changes in the Resident ' s medication orders and that she(Staff #A) was assisting the Resident with the correct medications, thereby placing the Resident at potential risk for a medication error.
At this point, the Surveyor intervened in the med pass, due to the potential for a medication error due to

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Staff #A not checking the MOR before placing the medications in a cup for the residents. Staff #A confirmed that this was her usual practice. The surveyor reiterated to Staff #A that it is essential to check the MOR before assisting the resident with self-administration of medications in order to assure that the residents receive the right medications, at the right time, in the right dosage, and for the right reason.

Class III

0056 Medication - Labeling and Orders

Based on observation, interview and record review, it was determined that the facility failed to obtain complete and accurate orders for the use of medications ordered by a health care provider for 4 of 10 residents (Resident #28, #14, #11, #1) reviewed for medication assistance and accuracy of orders on the medication observation record (MOR).
The findings include:
1) During a 12 PM observation of facility staff assisting residents with the self- administration of medications, it was observed that the , , 2015 medication observation record (MOR) for Resident #28 ' s MOR contained the following order- 1 mg (milligram), take 1 tablet by mouthy every 8 hours as needed. The order did not indicate the circumstances under which it would be appropriate for the Resident to request the medication. Upon further review of Resident #28 ' s MORs, it was noted that the same error also occurred on the Resident ' s MOR for , 2015 and , 2015. It was further noted that the name and telephone number of the Resident ' s healthcare provider, as well as any possible were not recorded on the MORs. Supporting documents were obtained.
During an interview with Staff # A, immediately following medication pass. Staff # A confirmed that the circumstances under which it would be appropriate for the Resident to request , were not included on the MOR. She further stated that she was not aware that such information was required and that she would assist the Resident with the medication if " if she says she needs it " .
2) Record review for Resident # 14, it was noted that the , , 2015 MOR for Resident #14 contained the following order- " Acetomen ( ) 500 mg every six hours as needed. Dr.XXXX " . The MOR did not specify under what circumstances it would be appropriate for the Resident to request the medication.
3)During a review for Resident #11, it was noted that the Resident ' s , , 2015 MOR contained the following order- " 800 mg. Take 1 tablet every 8 hours as needed. Dr. XXXX / " The MOR did not specify under what circumstances it would be appropriate for the Resident to request the medication.
4) A record review of Resident # 1 found an admission date of . Resident #1's AHCA 1823 assessment is dated for with a diagnosis of , , Dyslipidemia, , , and . Resident # 1 is alert and oriented x 2. She also requires assistance with self -administration of medications. Resident # 1's file revealed Resident # 1 is receiving Hospice Services

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as of 6/18/2015 with a diagnosis of . Further record review of Resident # 1's Medication Observation Records (MOR) and Hospice Physician orders revealed Resident # 1 was receiving ( ) 200 mg in the morning daily since . Resident # 1's physician order dated for indicates to discontinue previous order of 200 mg. The physician order dated for indicates a new order for at 150 mg (Copies Obtained). Resident # 1's physician order dated for / indicates "As of Resident # 1's medication of previous 200 mg order are to be discontinued" (copy obtained). A review of Resident # 1's Medication Observation Record (MOR) for . 2015 revealed Resident # 1 was receiving 200 mg from through ; as evidenced by signatures by staff who assist with self -administration of medications on the MOR who signed off that the medication 200 mg was given. As of / a review of Resident # 1's MOR indicates "discontinue 200 mg". A review of the MOR's dated for the month of and revealed a new order for (Bupropn) 150 mg not started until / and given daily at 8 AM (Copy Obtained).

In an interview with the Administrator on at 4:45 PM, he reviewed Resident # 1's physician orders and MOR's for the month of 2015 and the month of 2015. He acknowledged the error of staff continuing to give Resident # 1 the wrong dosage of from through /. The Administrator acknowledged that discontinuation of 200 mg was written on the MOR as of , and that no new order of 150 mg was not started until / /. He acknowledged that staff continued to give the wrong dosage of the medication until /. He stated no further information was available for review.

Class III

0078 Staffing Standards - Staff

Based on interview and record reviews, it was determined the facility failed to ensure all staff had documentation yearly indicating freedom from ( ), for 2 out 3 sampled employee records reviewed.

The findings include:

A review of the personnel files for Staff C and F revealed the following.

a) Staff C last examination was completed on . Further record review revealed no further documentation from a healthcare provider since noted dated indicating freedom from .

b) Staff F last examination was completed on . Further record review revealed no further

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documentation from a healthcare provider since noted dated indicating freedom from .

On 09/10/2015 at 04:50 P.M. a side-by-side review of the employee records were conducted with the facility Administrator for Staff C and Staff F, he acknowledged aforementioned .

Class III

0084 Training - Assis Self-Admin Meds & Med Mgmt

Based on observation, record review and interview, the facility failed to ensure that 1 out of 4 current employees (Staff F) had completed a 4-hour course in assistance with self-administered medications.

The Findings Include:

In an observation conducted on / at 5:35 PM, of the assistance with self- administration of medications, Staff F was observed assisting Resident with their self-administered medications.

A record review of Staff F ' s personnel file revealed a hire date of / / , it was noted that the record lacked the required certificate indicating she completed a 4-hour initial training course on assistance with self-administered medication and medication management.

In an interview conducted on at 4:45 PM, the Administrator reviewed the file and confirmed the findings.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observations and interviews the facility failed to provide a safe living environment, free of hazards and ensure that all electrical and mechanical systems are maintained in good working order.

Findings include:

a) During a re-licensure conducted at the Facility on at 11:07 A.M., a tour was conducted on Unit 200. An observation was made of the carpet in the hallway of this unit. The carpet consisted of a brown and beige blend. There was yellow stain, approximately 12 inches in length and approximately 6 inches in width. The carpet also contained large black stains in Unit 200 hallway

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910722	**09/10/2015**
NAME OF PROVIDER OR SUPPLIER **LAUDERHILL MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **2801 NW 55TH AVENUE LAUDERHILL, FL 33313**	

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

b) During a tour of Unit 200 on 09/09/2015 at 11:07 A.M., it was revealed that the three sectional beige couch in the sitting area was covered with large black stains on the pillows and the seats of the couch. (Photos were taken).

c) During the same tour of Unit 200 at 11:30 A.M. the Surveyor noted that the white exterior doors of Resident : 222, 223, 224, and 226 were noted with brown stains, dents, and scratches. (Photos were taken).

d) Additionally, on / at 11:53 A.M. broken floor tiles were detected near the entrance of the women's broken tiles were noticed in the hallway of foyer area leading to both male and female . (Photos were taken).

e) On that same date at 01:08 P.M., an observation was made of the ceiling in the . There was a tile square missing in the area of the overhead air conditioning unit, along with a blue towel hanging from a pipe of the air conditioning unit. An interview was conducted with Resident #16 in , who states that this air conditioning unit has been leaking for a few weeks, so he had to stuff the towel in the vent to discontinue the rain from falling onto the bed underneath the leak. He stated that he had mentioned this problem to maintenance and it had yet to be repaired. (Photos were taken).

On at 5:00 P.M. the Administrator was advised of the environmental issues and acknowledged the issues. He stated that he has been remodeling recently.

Class III

L243 LMH - Training

Based on record review, observation and interview, the facility failed to ensure that direct care staff receive 6 hours of specialized training in working with individuals with mental health diagnosis in 1 of 3 (Staff C) staff records reviewed.
The findings include:
A review of Staff C's personnel record revealed that she was hired on / and works as an aide on the 10:30 PM -7 AM shift.
A review of the personnel file of Staff C revealed that the record lacked the required Limited Mental Health training within 6 months of hire.
A review of the Facility's Staffing schedule for the weeks of - / revealed that Staff C was assigned , resident care duties on 9/4, 9/5, 9/7, 9/9, , / , / , / , and /
In an interview conducted on at 3:45 PM with the Administrator, he confirmed that Staff C works

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SUMMARY STATEMENT OF DEFICIENCIES
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providing direct care to residents on the 10:30 PM-7 AM shift, he reviewed the file, stated he had no other documentation to provide for review and confirmed the findings.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

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

RE: Relicensure Survey

Dear Administrator:

This letter reports the findings of a Relicensure survey that was conducted on , 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 attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than 22, 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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

XG90

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