STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910711	06/08/2016
NAME OF PROVIDER OR SUPPLIER **MIDTOWN MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **2001 POLK STREET** **HOLLYWOOD, FL 33020**	

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

0000 Initial Comments

A licensure compliant inspection survey, CCR#2016004818 was conducted from 6-7-16 to 6-8-16 at The Midtown Manor (license#). The facility had deficiencies identified at the time of the survey.

This survey was conducted in conjunction with the follow-up to the monitoring survey. See separate report for findings.

0030 Resident Care - Rights & Facility Procedures

Based on record review and interview, the facility failed to treat 2 out of 3 sampled discharged residents (Residents #10 and #11), with consideration and respect during their discharge process.

The findings are:

Review of the facility records indicated that Resident #10 was admitted on - and was discharged from the facility on - -, and Resident #11 was admitted on - - and was discharged from the facility on - -.

In an interview with Resident #10's daughter, on - at 11:35am, she stated that her mother's discharge from the facility was a "terrible and negative" experience. She stated that the Coolidge Palms assisted living facility administrator represented herself as the administrator for the facility and told her that her mother was admitted to another facility before being discharged on - - -. She stated that this individual later told her that her mother was not admitted into the other facility and this made it difficult for her to find a proper facility to place her mother in a short period of time. She stated that the facility did not provide her any notice by any physician to require her mother be transferred from the facility for medical reasons, or for any other reasons. She stated that the whole discharge process of her mother from the facility was unpleasant and disorganized, but she was glad her mother moved out of the facility.

Review of resident #10's record indicated that there was no facility notification to the resident/representative that required the resident be transferred from the facility for medical reasons, or for any other reasons.

In an interview with Resident #11's case manager on - at 9:55am, she stated that she was not pleased with the resident's discharge process. She stated that on - -, Resident #11 made his own decision to leave the facility without notifying anyone. She stated that the resident was capable of

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making his own decisions and he expressed to her that he was not pleased living in the facility. She stated that after she communicated with the resident on or about 4-9-16, the resident made the decision to not move back to the facility. She stated that she communicated this to the facility on or about and the facility immediately moved all of the resident's belongings out of his , while she had paid the facility for the resident's physical space and . She stated that when she went to pick up the resident's belongings sometime during the middle of 2016, the facility had placed all of the resident's personal items in the stairwell area located on the northwest side of the facility. She stated that where the facility placed these items, it was a common area that may be accessed by anyone inside the facility. She stated that initially there were some personal items that were missing and the facility did not assist her in retrieving these items. She stated that this was a very unpleasant discharge process for her and Resident #11.

Review of Resident #11's record indicated that the facility did not adequately account for the resident's personal items when he was admitted or discharged from the facility.

Class III

0053 Medication - Administration

Based on observation, interview and record review, the facility failed to ensure acceptable professional nursing standards of practice were followed for glucose monitoring for administration of . This was evidenced by the failure to conduct and document the glucose monitoring as ordered, for 3 of 3 sampled residents (Residents #1, #2, and #3).

The findings include:

Review of Resident #1 ' s Health Assessment form dated on / indicated that the resident required medication management and skilled nursing to administer . Review of the 2016 MOR indicated that Resident #1 had a diagnosis of dependent and was prescribed Lantus 50 units every morning and 55 units every evening. Additionally, the resident was ordered daily glucose testing/ monitoring in the morning and evening. Review of the 2016 Glucose Monitor Sheet indicated that on and , there was no documentation of the required morning and evening glucose testing noted by the nurse on the log. Review of the 2016 Glucose Monitor Sheet indicated that on , 3 and , there was no documentation by the nurse of the required evening glucose monitoring.

Review of Resident #2 ' s Health Assessment form dated on indicated that the resident required medication management and skilled nursing to administer . Review of the 2016

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MOR indicated that Resident #2 had a diagnosis of dependent and was prescribed 30 units every night and mix 35 units every morning and evening. Further review indicated that the resident was ordered daily glucose testing/ monitoring in the morning and evening. Review of the 2016 Glucose Monitor Sheet indicated that on there was no documentation of the required evening glucose testing noted by the nurse on the log. Further review of 2016 Glucose Monitor Sheet indicated that on 1 thru 3 there was no documentation by the nurse of the required morning and evening glucose monitoring.

Review of Resident #3 ' s Health Assessment form dated on indicated that the resident required medication management and skilled nursing to administer . Review of the 2016 MOR indicated that Resident #3 had a diagnosis of dependent and was prescribed Lantus 55 units every morning and 80 units every evening. Additionally, the resident was ordered daily glucose testing/ monitoring in the morning and evening.

Review of the 2016 Glucose Monitor Sheet indicated that on and 31st, there was no documentation of the required morning and evening glucose testing noted by the nurse on the log. Further review of 2016 Glucose Monitor Sheet indicated that on 1 thru 3 there was no documentation by the nurse of the required morning and evening glucose monitoring.

In an interview with the Administrator on at 2:00PM, she stated that the facility did not employ nurses, but contracted with a Home Health Agency to provide a nurse who would conduct glucose testing and administer to the residents as ordered by their physician. The Administrator stated that she would expect that the ordered glucose monitoring be completed by the nurse and documented in the resident ' s medical record along with the MOR. She stated that she was unaware that the testing had not been completed by the 3rd party provider nurse.

Class III

0054 Medication - Records

Based on observation, interview and record review, the facility failed to maintain an accurate daily medication observation record (MOR) for residents. This was evidenced by the failure of the nurse to accurately document the prescribed medications that were administered on the MOR, for 3 of 3 sampled residents (Resident #1, #2 and #3).

The findings include:

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Record review of the May 2016 Medication Observation Record (MOR) for Residents #1, #2 and #3 indicated that the residents had not been administered their medications as prescribed.

Review of Resident #1 ' s Health Assessment form dated on / indicated that the resident required medication management and skilled nursing to administer . Review of the 2016 MOR indicated that Resident #1 had a diagnosis of dependent and was prescribed Lantus 50 units every morning and 55 units every evening. Further review of the MOR indicated that on the evening dose was not administered and on both morning and evening was not administered as prescribed by the resident ' s physician.

Review of Resident #2 ' s Health Assessment form dated on indicated that the resident required medication management and skilled nursing to administer . Review of the 2016 MOR indicated that Resident #2 had a diagnosis of dependent and was prescribed 30 units every night and mix 35 units every morning and evening. Further review of the 2016 MOR indicated that the evening dose of was not administered on and on , both the morning and evening doses were not administered. Additionally, on the evening dose of was not administered.

Review of Resident #3 ' s Health Assessment form dated on indicated that the resident required medication management and skilled nursing to administer . Review of the 2016 MOR indicated that Resident #3 had a diagnosis of dependent and was prescribed Lantus 55 units every morning and 80 units every evening. Further review of the 2016 MOR indicated that on , both morning and evening doses were not administered as prescribed by the resident ' s physician.

In an interview with the Administrator on at 2:00PM, she stated that it was the facility policy, that when medication is administered to the resident, the MOR must be completed at that time. She stated that the facility did not employ nurses, but contracted with a Home Health Agency to provide a nurse who would conduct glucose testing and administer to the residents as ordered by their physician. The Administrator stated that she would expect that the ordered glucose monitoring be completed by the nurse and documented in the resident ' s medical record along with the MOR. She stated that she was unaware that the glucose testing and administration documentation had not been incomplete by the 3rd party provider nurse.

Class III

N277 LNS - Resident Care Standards

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Based on observation, interview and record review, the facility failed to ensure nursing services provided were conducted in a manner prevailing in the nursing community. This was evidenced by the failure to perform and document glucose monitoring and administration for 3 of 3 sampled residents, Resident #1, #2, #3 receiving Limited Nursing Services (LNS) for administration.

The findings include:

Review of the two facility Resident Medication Observation Record (MOR) log books on at 10:15 AM, indicated that the glucose monitoring log sheet for each resident receiving Limited Nursing Services for management were not observed stored along with the resident ' s medication records.

Review of Resident #1 ' s Health Assessment form dated on / indicated that the resident required medication management and skilled nursing to administer . Review of the 2016 MOR indicated that Resident #1 had a diagnosis of dependent and was prescribed Lantus 50 units every morning and 55 units every evening. Additionally, the resident was ordered daily glucose testing/ monitoring in the morning and evening. Review of the 2016 Glucose Monitor Log Sheet indicated that on and , there was no documentation of the required morning and evening glucose testing noted by the nurse on the log. Review of the 2016 Glucose Monitor Log Sheet indicated that on , 3 and , there was no documentation by the nurse of the required evening glucose monitoring. Review of the 2016 Medication Observation Record (MOR) indicated that on the evening dose of Lantus was not administered and on both morning and evening doses of was not administered as prescribed by the resident ' s physician.

Review of Resident #2 ' s Health Assessment form dated on indicated that the resident required medication management and skilled nursing to administer . Review of the 2016 MOR indicated that Resident #2 had a diagnosis of dependent and was prescribed 30 units every night and mix 35 units every morning and evening. Further review indicated that the resident was ordered daily glucose testing/ monitoring in the morning and evening. Review of the 2016 Glucose Monitor Log Sheet indicated that on 30th there was no documentation of the required evening glucose testing noted by the nurse on the log. Review of 2016 Glucose Monitor Log Sheet indicated that on June1 thru , there was no documentation by the nurse of the required morning and evening glucose monitoring. Review of the 2016 Medication Observation Record (MOR) indicated that the evening dose of was not administered on and on , both the morning and evening doses were not administered. Additionally, on the evening dose of was not administered.

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Review of Resident #3 ' s Health Assessment form dated on indicated that the resident required medication management and skilled nursing to administer . Review of the 2016 MOR indicated that Resident #3 had a diagnosis of dependent and was prescribed Lantus 55 units every morning and 80 units every evening. Additionally, the resident was ordered daily glucose testing/ monitoring in the morning and evening. Review of the 2016 Glucose Monitor Log Sheet indicated that on and , there was no documentation of the required morning and evening glucose testing noted by the nurse on the log. Review of 2016 Glucose Monitor Log Sheet indicated that on 1 thru , there was no documentation by the nurse of the required morning and evening glucose testing. Review of the 2016 Medication Observation Record (MOR) indicated that on 31st, both morning and evening doses of Lantus were not administered as prescribed by the resident ' s physician.

In an interview with the LNS nurse on at 10:45 AM she stated that she was contracted by the facility to provide monthly nursing services, to include assessment and monitoring of residents identified by the facility to require Limited Nursing Services (LNS). She stated that she made monthly visits and had monitored Resident ' s #1. #2 and #3 for management. The nurse stated that she does not administer the prescribed or conduct the glucose testing but that the facility and residents contract with a 3rd party health care provider to perform those tasks. The nurse stated that in her professional opinion, when daily glucose testing and administration is ordered, she would expect the " nurse " to complete the glucose test and document the results in the resident ' s facility medical record. Furthermore, she stated that after any medication is administered to a resident, the nurse should document the administration in the MOR. She stated that there should be no blank spaces/ dates on the MOR when medication has been prescribed for the resident.

In an interview with the Administrator on at 2:00PM, she stated that the facility did not employ any nurses on staff, but contracted with a Home Health Agency to provide a nurse who conducted glucose testing and administered daily to the residents as ordered by their physician. She stated that the LNS nurse visited monthly but did not provide administration or glucose monitoring. She stated that she would expect that the appropriate glucose monitoring be completed by the 3rd party nurse and test results documented in the resident ' s medical record along with the MOR. She stated she had not been notified by the facility staff that the glucose testing logs were not being stored with the resident ' s records and that the MOR records had not been completed by the 3rd party provider nurse consistently.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Midtown Manor
2001 Polk Street
Hollywood, FL 33020

RE: CCR #2016004818

Dear Administrator:

This letter reports the findings of a State Licensure Survey that was conducted on , 2016 by representative from 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 , 2016.** 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 representative. Should you have any questions please call this office at (561) 381 - 5840.

Sincerely,

Arlene Mayo - Davis
Field Office Manager

AMD/jw
Enclosure
XG90

Delray Beach Field Office
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