STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910711	**07/27/2016**
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

On 07/26/2016 and 07/27/2016, a Biennial Licensure plus Limited Mental Health survey was conducted at Midtown Manor, license number 6508. Deficient practice was identified during the survey.

0010 Admissions - Continued Residency

Based on interviews and record reviews, the facility failed to ensure the required Interdisciplinary Care Plan ( ) was developed for a resident admitted to hospice services for 1 of 2 sampled Residents (15).

The findings included:

Review of Resident 15's records conducted on revealed the following:

1. She was admitted to the facility on with diagnoses including , high , and . She was admitted to hospice services on , and is currently still receiving hospice services.

2. A hospice integrated care plan documented specific details related to the residents health care needs and the hospice services to be provided to the resident by hospice staff.

3. There was no record of an developed by hospice in consultation with the assisted living facility (ALF) that identified specific services to be provided by hospice staff and specific services to be provided by ALF staff.

In an interview conducted around 2:00 PM, the Administrator stated she would contact the hospice team and request the required . At 5:27 PM, the Administrator stated she had not yet received the .

Class III

0030 Resident Care - Rights & Facility Procedures

Based on observations, interviews and record review, the facility failed to ensure a safe and decent environment consistent with established and recognized standards for 6 of 7 resident observed (111, 115, 117, 221, 318 and 319); one random resident observation (18); 2 resident community rest and 1 staff rest ; and, one housekeeping cart.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910711	**07/27/2016**
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)

The findings included:

Tours of the facility and resident rooms were conducted during the two-day survey. The following concerns were identified (photographic evidenced obtained):

1. On at 12:15 PM, an unsupervised housekeeping cart was observed in the hallway of the third floor. The cart contained cleaning chemicals, one bottle of cleaning agent had no cover. The Housekeeper was not present. At 12:20 PM, the elevator was heard to open and Employee I, a Housekeeper, came down the hall. When asked why she left the cart unsupervised, she repeatedly stated, "No comprende" ("I don't understand" in Spanish). On at 12:47 PM, the housekeeping cart was observed unsupervised again. At 12:50 PM, Employee I was heard to arrive on the elevator and returned to her cart.

2. Resident 15 resides in . Review of her records revealed she was admitted to the facility on . She was admitted to hospice services on related mainly to a diagnosis of with acute exacerbation and requires continuous . The following observations were made on at 3:13 PM:
A. The intake vent to her concentrator unit was completely covered with a thick layer of dust and debris.
B. The end of the plastic tubing connected to her (breathing treatment) unit that would attach to the resident's face was observed laying on the floor.
Repeat observations of the above items were made on around 3:55 PM with the Administrator present.

3. Resident 18 was observed on at 11:31 AM in her reclining wheelchair in the dining . The wheelchair's arms and back and flap connecting the seat to the leg cushion, and entire inner plastic and metal side walls were excessively soiled. There was excessive food debris and soil buildup in the crevasses between the arm cushions and metal arm frames. At 12:10 PM, a tiny black insect was observed to run across the right horizontal metal arm frame and under the arm cushion. At 12:12 PM, a second tiny black insect was observed to run up the right vertical metal arm frame and into a crevasse in the metal frame. At 12:14 PM, a small light brown ant was observed on the right arm cushion. Employee G, a dietary staff member, was present and the ant was brought to her attention. Employee G squished the ant at the time of observation.

4. Resident 13 resides in . On at 12:20 PM, a unit was observed on her nightstand. The unit was soiled and mildly dusty. The mask that attaches to the resident's face contained an unknown form of debris.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910711	07/27/2016
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)

5. Observations of resident and staff rest rooms revealed empty toilet paper dispensers with partially-used rolls of toilet paper stored on the top of the dispensers, on sink vanities, on the back of the toilet or on hand rails in the following rest :
A. Resident 111, 115, 117, 221, 318 and 319
B. The first floor men's rest
. The first floor women's rest
. The staff rest the dining the kitchen (the hand soap dispenser and paper towel dispenser were also empty)

These concerns were discussed with and acknowledged by the Administrator on beginning at 3:07 PM. She observed many of the concerns identified above.

Class III

0055 Medication - Storage and Disposal

Based on observations, interviews and record review, the facility failed to ensure medications belonging to residents who require assistance with self-administration of medications were centrally stored for 2 of 7 sampled Resident (16 and 17). Medications were observed stored in the residents' .

The findings included:

A tour of resident conducted during the two-day survey revealed the following concerns:

1. On at 11:55 AM, a cardboard box about 9"x15" was observed on Resident 16's nightstand. It contained multiple over-the-counter medications and a prescription medication. On at 3:30 PM with the Administrator present, the contents of the box revealed the following items:

A. A bottle of prescribed 20 milligrams (MG)
B. Efferdent anti- cleanser
C. Two containers of VapoRub suppressant
D. 800 micrograms (MCG)
E. Sugar-free iron 65 MG
F. with D3

Review of Resident 16's AHCA Form 1823 (medical examination) dated / documented he requires assistance with self-administration of medications. Further review revealed no orders for the

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910711	**07/27/2016**
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)

items listed above, nor was there written documentation from a Health Care Provider (HCP) showing he was approved to maintain any of the OTC products or prescription medication in his room.

In an interview conducted at 3:30 PM, the Administrator reviewed the items decribed above and stated Resident 16 requires assistance with self-administration of medications. She further acknowledged these items should not be stored in the resident's .

2. On at 11:51 AM, a partially-used tube of 0.05% was observed on Resident 17's nightstand. There was no cap on the tube. There was no box for the tube and no prescription label affixed to the tube. Review of Resident 17's AHCA Form 1823 (medical examination) dated revealed she required assistance with self-administration of medications. Further review revealed no written HCP order for this medication, nor was there written documentation from a HCP showing she was approved to maintain this prescription medication in her .

In an interview conducted at 3:13 PM, the Administrator observed the medication stored on Resident 17's nightstand. She acknowledged this medication should not have been stored in the resident's .

Class III

0080 Training - Core & Competency Test

Based on record review and interviews, the facility failed to ensure the facility's Manager (Employee F) received the required assisted living facility Core Training and passed the Core Competency Test in a timely manner.

The findings included:

Employee file review conducted revealed the following concern. Personnel records for Employee G, the facility's Manager (the Administrator represents two facilities) documented she was hired on . She became the facility Manager in 2015. Her records documented she completed the required Core Training in 2016, at least 8 months later. She was scheduled to sit for the Core Competency Test on , about 4 months after completing the training. In an interview conducted around 3:30 PM, Employee F confirmed the above information.

Further review of her personnel file revealed no documentation showing she completed the Core Training within 3 months of becoming the facility's Manager. There was no documentation showing she took and passed the Core Competency Test in a timely manner.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910711	07/27/2016
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)

This was discussed with and acknowledged by the facility's Administrator on 07/27/2016 around 4:30 PM.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observations and interviews, the facility failed to provide residents an environment with all architectural, mechanical, electrical systems and appurtenances in good working order for 7 of 7 resident observed (111, 115, 117, 221, 222, 318 and 319) and in common areas, hallways and community rest .

The findings included:

Tours of the facility were conducted throughout the two-day survey. The following concerns were identified (photographic evidence obtained):

1. On at 10:50 AM, in the first floor men's rest :
A. The cabinet for the sink was excessively soiled and worn. The bottom facing was deteriorating and very unsightly.
B. The area around the rest was excessively soiled.
C. The walls and floor around the toilet were soiled.
D. The plumbing for the toilet was deteriorating and very unsightly.

2. On at 11:02 AM, a wall-mounted water fountain and stand-alone water dispenser located between the ladies and men's rest on the first floor were observed. The water fountain was , water was not able to drain and had pooled in the fountain basin. The water dispenser unit was leaking, there were linens on the floor to absorb the leaking water. The 5-gallon water bottle on the water dispenser was empty, one drinking cup sat on top of the water bottle. The surrounding area was soiled and unsightly.

3. On at 11:09 AM, the walls near the water fountain described above had areas of chipped paint. In the first floor west wing resident hallway, 5 large unfinished wall repairs were observed.

4. On at 11:13 AM, in the first floor west wing resident hallway, the 2 windows at the end of the hallway had excessive black matter running along the bottom of the 2 window panes.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910711	07/27/2016
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)

5. On 07/26/2016 at 11:35 AM during dining observations, a large quantity of plastic white or beige-colored coffee mugs were observed. All the white coffee mugs contained dark unsightly stains inside the coffee mugs.

6. On at 3:13 PM, the following concerns were identified in resident :
A. Refrigerator interior was soiled, one shelf was excessively rusty
B. The resident installed padding to a corner of the wooden dresser because, "I cut my arm on it a little while back."
C. The resident's family member taped an extension cord to the electrical outlet with plastic packing tape to prevent the plug from falling out of the electric outlet. The electric outlet had no protective cover, the interior of the electrical outlet was exposed. Debris and soil above the electrical outlet prevented the plastic tape from sticking to the wall above the electrical outlet. The area surrounding the outlet had numerous tiny black specks and was unsightly.
D. The was excessively scuffed and was unsightly
E. The entire was excessively soiled and had a rust-colored stain near the toilet base
F. The toilet base was excessively soiled, the toilet seat and the over-toilet commode seat and frame were excessively soiled and worn
G. The light fixture above the entrance door was missing its cover
H. Paint on the wall was chipped in 3 places above the head of the resident's bed and was unsightly
I. Paint on the wall was chipped in 3 places on the wall to the left of the television and was unsightly

7. On at 11:36 AM:
A. In the resident :
i. The floor was excessively soiled, especially behind the toilet base
ii. A mental vent cover was stored on the floor behind the sink pedestal
iii. The plumbing to the toilet was deteriorated and unsightly
. The over-commode toilet seat was soiled and excessively rusty
v. The ceiling fan had no cover and was exposed and unsightly
vi. A ceiling tile was soiled, another ceiling tile was missing
vii. There was no shower curtain on the shower
viii. In the resident's :
ix. The entrance door had chipped paint
x. The wall behind the entrance door was in disrepair and had an unfinished wall repair
xi. There were black spots on the floor behind the entrance door
xii. The 2 window blinds were in disrepair
xiii. An electric outlet had no protective cover, the interior of the electrical outlet was exposed
xiv. The top surface of a night stand was worn, stained and unsightly

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910711	**07/27/2016**
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)

8. On 07/27/2016 at 11:45 AM, the floor of the west wing elevator was excessively chipped at the entrance and was unsightly

9. On at 11:51 AM, the following concerns were identified in resident :
A. The was excessively soiled
B. The over-commode toilet seat was worn and rusty
C. The plumbing to the toilet was deteriorating and rusted
D. The shower seat was rusted, it was repaired with gray duct tape at the front of the seat
E. The shower floors were soiled

10. On at 11:52 AM, in resident , the was soiled and rusty

11. On at 11:55 AM, the following concerns were identified in resident :
A. The beige bedspread on the left bed had white stains throughout.
B. The :
i. 7 holes in the wall below the handrail to the right of the toilet
ii. Brown matter was observed on the wall to the right of the toilet
iii. Ceiling tiles were excessively soiled
. The floor was soiled, especially around the toilet base

12. On at 12:20 PM, the following concerns were identified in resident :
A. The dresser had old adhesive tape on 6 drawer faces and was unsightly
B. A tile had broken away from the wall and was sitting on the floor near the entrance door
C. The :
i. Excessive rust stains on the floor under the sink and on the shower floor
ii. Holes in the wall under the handrail to the right of the toilet where a prior toilet paper holder had been installed, and was unsightly

13. On at 12:55 PM, the following concerns were identified in resident :
A. The interior of the refrigerator was soiled
B. A pie stored on a dresser was extremely moldy
C. In the :
i. The floor was soiled
ii. The plumbing to the toilet was rusty and deteriorating
iii. A toilet paper holder had one bracket off and was a safety hazard and was unsightly
. The shower floor was soiled
v. A ceiling tile was soiled

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910711	**07/27/2016**
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)

14. On 07/27/2016 at 2:02 PM, in the first floor ladies rest room:
A. There was excessive soil build up around the door jamb and door
B. The floor at the base of the sink vanity and toilet was excessively soiled
C. Paint was chipped around the sink vanity and was unsightly
D. The right faucet on the sink had a portion of the handle missing
E. An unfinished wall repair around the toilet paper dispenser was very unsightly
F. Paint was chipped across the length of the toilet tank
H. The floor around the toilet was excessively soiled
I. The sink cabinet was excessively soiled and worn, the bottom facing was extremely deteriorated and very unsightly

These concerns were discussed with and acknowledged by the Administrator on beginning at 3:07 PM. She observed many of the concerns identified above.

Class III

L241 LMH - Records

Based on interviews and record review, the facility failed to ensure required documentation was obtained for 1 of 3 sampled Limited Mental Health Residents (13). There was no record of what type of social security benefit the resident received.

The findings included:

Review of Resident 13's records conducted revealed she was admitted to the facility on . Her AHCA Form 1823 (medical examination) dated documented a pertinent diagnosis of , . Form CF-ES 1006 dated documented she receives Optional State Supplement benefits related to a mental .

Further review of Resident 13's records revealed no written verification provided by the Social Security Administration (SSA) that she receives either Social Security Income or Social Security Income related to a mental .

This was discussed in an interview with the Administrator conducted at 3:45 PM. Proof of verification from the SSA related to Resident 13 was requested. The Administrator stated she was not familiar with this requirement, the CF-ES 1006 form, or what type of social security benefit Resident 13 received. She stated she would look in to it. At 5:15 PM, the Administrator was asked and stated she did not have the required documentation.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910711	**07/27/2016**
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)

Class

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Midtown Manor
2001 Polk Street
Hollywood, FL 33020

RE: Limited Mental Health (LMH) survey

Dear Administrator:

This letter reports the findings of a LMH state licensure survey that was conducted on 27, 2016 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. **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/dso
Enclosure
XG90

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com