STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910711	08/18/2016
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

CCR#s 2016007853, 2016008656 and 2016008705

Complaint inspections were conducted from 8-15-16 to 8-18-16. The Midtown Manor assited living facility was not found to be in compliance during this visit.

0025 Resident Care - Supervision

Based on observation, interview and record review, the facility failed to provide adequate assisted living services to 1 out of 5 residents (resident #17) by not having general health, safety and physical well-being awareness of the resident.

The findings include:

In an observation on - - at 11:15 am, Resident #17 had a and black colored on her left heel, which was approximately 2 inches in diameter. In an interview with the home care nurse at this time, she stated that the resident needed to receive to control the and to her left heel . In an interview with the resident at this time, she stated that she needed to propel herself with her heels since her wheelchair had four small wheels and she would sometimes propel herself with her bare feet without any protection to her heel.

In an interview with Resident #17 on - - at 11:30 am, she stated that she ambulated independently using her wheelchair without any staff assistance. She stated that it was difficult for her to ambulate independently because she developed a pressure on her left heel and she needed to use both of her feet to propel herself in the wheelchair she was provided. She stated that she needed to use a wheelchair to ambulate and the wheelchair she had, did not have large rear wheels to propel herself with her upper extremities, she could just use her lower extremities for this. She stated that the facility staff was aware of her mobility difficulties during the last couple weeks and they have not arranged for her to receive a proper wheelchair to use or a to reduce the pressure she put on her heel.

Review of Resident #17's record indicated that on -|- , she by the elevator without any facility staff supervision and the resident complained of hip pain. Review of this record indicated that the resident was transferred to the hospital on -|- and it did not specify the manner in which the resident that day. Review of the observation log dated on - - indicated that the facility was notified by the hospital that the resident was planned to go to a nursing home to receive physical rehabilitation since the resident her hip and was not able to walk or transfer independently. Review of the observation log dated on - indicated that the resident returned to the facility with new medication orders.

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Review of Resident #17's health assessment dated on 6-27-16 indicated that she was diagnosed with status post , left hip , failure, , and . Review of this health assessment indicated that she needed a wheelchair to ambulate, had modified independence due to her /behavioral status and needed precautions. Review of this health assessment indicated that the resident needed to receive physical and occupational evaluations and treatments. Review of this health assessment indicated that the resident needed supervision with her ambulation and was independent with all of her other activities of daily living (ADLs).

Review of Resident #17's observation log dated on - she on the floor inside her later outside in the patio, and she declined to go to the hospital both times. Review of the observation log dated on - indicated that the resident was seen by the physician who recommended for the resident to return to the nursing home. Review of the observation log dated on - - indicated that the resident was found in her bed with , and feces on the bed sheets, and was transported to the hospital. Review of this observation log indicated that the resident returned to the facility the same day on -. Review of the observation log dated on - indicated that the resident had a on her left heel and was treated by the podiatrist. Further review of the resident's record indicated that there were no physician orders for a large-wheel wheelchair which the resident may propel using her upper extremities and there were no physical or occupational evaluation results.

In an interview with the Assistant Administrator on - - at 1:30 pm, she stated that Resident #17 did not receive any physical or occupational since she returned to the facility on -. She stated that she was aware that the resident's health assessment dated on - indicated that the resident needed physical and occupational , but the facility did not ensure that the resident received that. She stated that the facility did not consider to get the resident a new wheelchair and she did not know why the facility did not arrange for the resident to receive a large rear wheel wheelchair so she may use her upper extremities to ambulate instead of her heel.

In an interview with the Assistant Administrator on - - at 2:00 pm, she stated that Resident #17's physician recommended the resident to be transferred to the nursing home on -, but the facility did not follow-up on this physician order.

In an interview with the Medication Technician on - - at 2:15 pm, he stated that he was aware of Resident #17's left heel and that she used a wheelchair for ambulation which potentially made her left heel worse since the resident used her feet to propel herself in the wheelchair. He stated that the resident was only able to use her feet to propel herself on the wheelchair because she used a

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wheelchair that did not have large rear wheels to grip with her hands. He stated that he was not aware of the Resident's ADL needs because the facility did not ensure that she receive physical or occupational therapies when she returned to the facility on 6-30-16. He stated that he knew that the physician recommended on - that the resident return to the nursing home to receive physical rehabilitation, but the facility did not follow up on the physician's recommendation.

In an interview with the Physician Extender on - at 10:30 am, she stated that she was aware of Resident #17's condition relating to her left heel and that it had been getting worse in the last week. She stated that she ordered for the resident to wear a over her left heel/foot to help reduce pressure a couple days ago and the resident did not currently have this on. She stated that the resident will benefit from using a wheelchair which she could use her upper extremities to propel herself with, instead of using her heels/feet to propel herself. She also stated that the resident will greatly benefit from physical and occupation evaluations so she can improve her physical function and her ADL needs can be established.

Class II

0056 Medication - Labeling and Orders

Based on observation, interview and record review, the facility failed to obtain medications prescribed by a health care provider in a timely manner. This was evidenced by the failure to obtain and assist with self- administration of a prescribed medication and failure to communicate observations of skin condition for 1 of 5 sampled residents, (Resident #18) who was experiencing chronic skin eruptions over the entire body and intense continuous itching.

The findings include:

Review of Resident #18 medical record indicated the resident was admitted to the facility on Review of the Resident Health Assessment form dated on indicated that Resident #18 had diagnoses including , , , , , , and . Further review of the form indicated that the resident was non-ambulatory, used a wheelchair for mobility and required total care for all her activities of daily living (ADL).

In an observation of Resident #18 on / at 11:35 AM she was observed sitting in her wheelchair in the dining . The resident was scratching her arms, repeatedly touching her face and rubbing her eyes. When questioned by the surveyor how she was feeling, the resident became agitated and yelled out "I am itchy all over my body, I need my cream. Please help me. Please I need to see the doctor. I have told the Caregiver and Manager no one is helping me. Please call the doctor." The resident lifted

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the sleeve of her shirt and numerous raised bumps were observed on the resident's left .

In an interview with the Caregiver on at 11:45 AM, she stated that she regularly cares for Resident #18. She stated that the resident is , non-ambulatory and required total ADL care. The caregiver stated that the resident was and was constantly itching and picking at her skin. She stated that she bathed the resident and had observed numerous scratch marks and wounds over the resident's body. When asked what care orders she followed for the resident's itching, the caregiver stated that the resident had previously been prescribed cream, and it had run out. The caregiver stated that she had not notified the manager, medication technician or administrator about the resident's continuous itching since the "resident had history of that behavior."

In an additional observation of Resident #18 on / at 1:00 PM. the resident was transported to the the caregiver. The resident's pants were observed to have dried red spots on the outside of each pant leg. The resident stood, and the caregiver lowered the resident's pants. Numerous wounds were observed on the front of both lower legs. (See photo evidence) Several wounds had scab formation and other wounds were actively and reddened. The resident started to yell out loudly." I am itching all over. I want to see the doctor now. Call the doctor. No one listens to me. I need my cream. "The resident was being transported back to the activity the caregiver and another care staff attempted to speak to the resident and reassure her, but the resident became more agitated and loudly yelled out again, "I need my cream. I need my cream. Call the doctor. I need to see the doctor."

Review of the facility progress notes dated on indicated no documentation of any skin condition on the resident.

Review of the health care provider note dated on indicated that the resident had complained of a to her trunk, which was very itchy and worse at night. Further review of the note indicated that the resident had medical diagnoses including unspecified , Parkinson 's , incontinence, , kidney failure, in both eyes, , and . The note indicated that the resident was diagnosed with and cream was prescribed. Review of the 2016 Medication Observation Record (MOR) for Resident #18 indicated no documentation of the cream application as prescribed.

Review of the facility progress notes dated on indicated no documentation of any skin concerns for Resident #18. No additional notes from any other dates in were observed in the record.

Review of a physician order dated on , indicated a prescription for Lotrisone 1% cream

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(/) to be applied to affected areas twice daily for 7 days. Review of the 2016 Medication Observation Record (MOR) for Resident #18 indicated no documentation of the Lotrisone cream application as prescribed. The resident did not receive the Lotrisone cream for 6 days, then started the treatment on 1.

Review of the health care provider note dated on indicated that the Resident #18 was seen for a , which was being treated with Lotrisone cream. The note indicted that the was improving, but the resident still complained of itching. The note further indicated that a consult had been ordered and the treatment was to continue until the resident was seen by the provider. Review of a medication order dated , indicated to continue the Lotrisone cream twice a day for 7 additional days.

Review of the 2016 Medication Observation Record (MOR) for Resident #18 indicated documentation of the Lotrisone cream application from 1 through 7. Further review indicated the resident did not receive the cream for the additional days as ordered by the health care provider.

Review of the facility progress notes dated on indicated that Resident #18 was seen by the health care provider. No additional documentation regarding the resident ' s skin condition was noted in the resident's progress note.

Review of the provider note dated on / , indicated that Resident #18 was examined for the chief complaint of on her trunk and arms. The note indicated that the was itchy, red, moderate in severity and had been present for months. The note indicated a diagnosis of and papulas were distributed over the right lateral , chest and left anterior shoulder and a prescription, dated / , for 0.1% (medium to strong potency) cream was to be applied twice daily to the itchy skin until healed. The note indicated 3 refills were available to the resident.

Further review of the 2016 Medication Observation Record (MOR) for Resident #18 indicated that the 0.1% cream was applied twice daily from 12 through 31st.

Review of the facility progress notes for 2016 indicated no documentation regarding the resident's skin condition or any interventions and results of the skin treatments for Resident #18.

Review of the health care provider note dated on indicated that Resident #18 was seen for refusing to take her medications. The note further indicated that the resident was complaining of a persistent on her back and shoulders. The note indicated that the had improved with the use of the 0.1% cream ordered by the dermatologist. The health care provider

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assessed the resident to have no discoloration on the lower extremities but a small on the right was noted with mild around the area. Additionally, a dime sized raised scaly was noted below the left knee and a dermatology consultation was ordered. Staff were instructed to monitor the to right for signs of . The note indicated to resume the 0.1% cream to the affected area of back and shoulders twice daily for 14 days.

Review of the 2016 Medication Observation Record (MOR) for Resident #18 indicated documentation of the 0.1% cream was applied twice daily beginning on 20th through . The prescription treatment was delayed from until , the resident did not receive the treatment for 16 days.

Review of the provider note dated on indicated that Resident #18 was examined for chief complaints of skin on her nose and left area and itching on the legs, arms and trunk. The itching was noted to be constant, worsening at night and moderate in severity. The note indicated that the itching kept Resident #18 up at night and has been present for months. Further review of the note indicated that the resident had neurotic sparing where she could not reach, and was distributed on the left , dorsal , right , dorsal , right , region, and left area. The were caused by scratching the skin. The provider noted that discovering the underlying cause was difficult, due to the overlying skin damage, masking the underlying primary . The plan included to contact the provider with any observations of new and to apply 0.1% cream twice daily to itchy skin up to 2 weeks / month as needed. 3 refills were included on the prescription.

Review of the facility progress notes from 2016 to present indicated no documentation of any skin concerns, observations or skin monitoring for Resident #18.

Review of the 2016 and 2016 Medication Observation Record (MOR) for Resident #18 indicated no documentation that the 0.1% cream had been administered.

In an interview with the medication technician (med tech) on at 1:15 PM, he stated that the facility caregivers had not notified him of the resident ' s complaint of itching. He stated that there was no 0.1% cream available and he would need to call the pharmacy to order the cream. He stated that the cream had not been refilled for several months.

In an interview with the health care provider on at 4:00 PM she stated that Resident #18 had a history of chronic and itching over her entire body. She stated that the scratching/ itching had been ongoing for months and a consult had been ordered to evaluate the skin concerns. She stated that Resident #18 was prescribed 0.1% cream and the had

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improved but the resident continued to scratching her skin. She stated that she had seen the resident on 7/21/2016 and the resident remained , had a history and was unable to communicate her needs well, therefore the staff must notify the healthcare provider with any changes or observations of the resident. When the surveyor informed the health care provider of the resident observations on , of constant itching/scratching and that the prescribed cream had not been refilled or administered to the resident, the provider stated "the poor thing." She stated that she had not been notified by the facility that the resident continued to experience constant itching and had developed open wounds. She stated that she would recommend a evaluation to determine any changes with the resident.

In an interview with the provider on at 2:30 PM, she stated that she had last evaluated Resident #18 on . She stated that the resident had complained of itching and was prescribed 0.1% cream twice a day. She stated that the actual precipitating cause of the itching was difficult to determine, but could have a component associated with it. She stated that she observed the resident to have evidence of itching without any exposure. She stated that "an itch can make you go crazy when not treated." She expressed that she was very concerned that Resident #18 had not been receiving the cream as ordered and had no relief from the itching.

In an interview with the Administrator on at 12:00 PM, she stated that Resident #18 was being followed by her primary health care provider and a consultant had been conducted with medications ordered for the resident's symptoms. The Administrator was informed that the skin cream prescribed by the consultant had not been refilled/administered for months and Resident #18 continued to experience constant itching. She stated that the healthcare provider had been notified that morning and an evaluation was completed on . She stated that the prescription cream had been ordered, received and applied to the resident that morning. She could not explain why the facility staff had not communicated the resident's ongoing symptoms to her, to the med tech, or healthcare providers.

Class II

0093 Food Service - Dietary Standards

Based on observation and interview, the facility failed to protect its food items so as to prevent spoilage and to ensure this food met its nutritional value for resident consumption.

The findings are:

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In an interview with Resident #15 on 8-15-16 at 1:20 pm, he stated that he felt that the facility meals were not good. He stated that often the facility would serve salads and bread that were unpalatable and tasted like they were spoiled. He stated that this food was likely not as nutritious as fresh or unspoiled food.

In an interview with Resident #11 on - - at 10:50 am, she stated that the facility served bread that was hard and unpalatable, and it was hard on her . She stated that this bread was likely not as nutritious as a fresh and soft loaf of bread.

In an interview with Resident #17 on - - at 11:30 am, she stated that she felt that the facility meals were not good. She stated that often, the facility would serve meals that were unpalatable and sometimes tasted like it had spoiled ingredients.

In an observation on - - from 12:30 pm to 12:45 pm inside the facility's reach-in refrigerator, there were six loaves of bread and two lettuce heads that had packaging with labels that indicated that this food was expired or it did not have its complete nutritional value. In an observation at this time, the bread was packaged in bags with labels that indicated "sell by" - , - , - and - . In an observation at this time the bread presented to be discolored with irregular white and black spots, and was irregularly hard to the touch. In an observation at this time, the lettuce heads were packaged in bags with labels that indicated the date - and presented to have discoloration with a black viscous substance on its leaves.

In an interview with the Kitchen Manager on - - at 12:40 pm, she stated that she stored the residents' food inside the reach-in refrigerator and that she was not aware that observed bread and lettuce had physical signs which may degrade its nutritional value. She stated that she did not know what the labels on the bread and lettuce packaging meant or if those labels indicated an expiration period of when the food became degraded or unsafe for resident consumption.

In an interview with the Kitchen Manager on - - at 12:50 pm, she stated that she usually served the residents the bread and lettuce inside the reach-in refrigerator which looked right to her without consideration of the dates on the food packaging labels.

In an interview with Resident #25 on - - at 10:50 am, she stated that she felt that the facility meals were terrible. She stated that often, the facility would serve meals with bread that was hard and unpalatable, and tasted like it was spoiled. She stated that this food was likely not as nutritious as fresh or unspoiled food.

In an interview with Resident #24 on - - at 2:40 pm, she stated that she felt that the facility meals

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were not good. She stated that often, the facility would serve meals with bread and salads that were not fresh. She stated that this food was likely not as nutritious as fresh food.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Midtown Manor
2001 Polk Street
Hollywood, FL 33020

RE: CCR #2016007853, #2016008656 and #2016008705

Dear . Sammie Castro, Administrator:

This letter reports the findings of complaint inspections conducted from to by representatives of the Agency for Health Care Administration. You are directed to comply with the tangible steps outlined below in order to correct the deficient practices. Attached are the deficiencies noted in the investigations.

The investigation resulted in findings of noncompliance with the following areas:

A 25 – Resident Care Supervision - Class II – The facility failed to provide adequate assisted living services to one resident by not having general health, safety and physical well-being awareness of the resident.

A53- Medication- Administration –Uncorrected Class III – The facility failed to ensure professional nursing standards of practice were followed for glucose monitoring for administration of .

A54 - Medication Records – Uncorrected Class III – The facility failed to ensure staff correctly documented the administration of resident medication.

A 56 – Medication Labeling and Orders – Class II – The facility failed to obtain medications prescribed by a health care provider in a timely manner for one resident.

Your facility must comply with the following:

1. The facility is required to develop and implement a comprehensive policy and procedure for monitoring the care and safety needs of all residents in the facility, with consideration of each resident's functional ability, physical/sensory limitations, /behavioral status, supplemental service requirements and special precautions, including but not limited to implementation of and accident prevention strategies, based on each resident's health assessment. This must be completed by .

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2. Any resident identified by any direct care staff member to have functional abilities, physical/sensory limitations and /behavioral status inconsistent with their current health assessment or needing supplemental services and special precautions not identified in their current health assessment, must immediately be referred to undergo a physician/physician extender examination for determination of the resident's current needs. This process must be implemented upon receipt of this DPOC.

3. This resident care and service policy and procedure must include maintenance of an up-to-date log identifying residents needing any special precautions, the facility staff person(s) responsible to deliver, supervise and/or coordinate the care and services, and the type and frequency of care and service each resident is to receive based on their health assessment. The type and frequency of the required care and service for each resident may include, but is not limited to, receiving specialized physical and occupational and using assistive devices. This must be completed by .

4. Your facility must develop a detailed written policy outlining your facility's practices for unlicensed staff assisting residents with self-administration of medications. The policy must include specific documentation of each staff's role in providing prescribed medications to the resident. The policy must include the procedure by which care staff are to communicate any resident medication needs. The policy must address each staff's role in the daily observations of any symptoms/behaviors and who is responsible to document in the resident record and notify the Administrator and health care provider. The policy will address that all resident observation documentation will be mandatory and any noncompliance with the policy will result in immediate disciplinary action by the Administrator. The policy will be included in the orientation of new unlicensed staff assisting residents with self-administration of medications. This requirement must be completed by .

5. All staff providing assistance with self-administration to residents must be re-trained in correctly providing assistance with self-administration of medication. The training shall cover state law and rule requirements and be conducted by a registered nurse or licensed pharmacist. This requirement must be completed by .

6. Your facility must contract with an outside consultant pharmacist to audit your medications, medication carts and storage and medication observation records. The outside pharmacy consultant shall also assist with the development of the policy noted in items #1 and #4. This requirement must be completed by .

7. Your facility must develop a written policy outlining your facility's practices and controls related to ordering, receiving, dispensing and administering of medications in the facility. This requirement must be completed by .

8. The facility must develop and implement a policy and procedure for the coordination of care between third party providers and the facility. The policy must include how the facility will coordinate and provide oversight of the third party provider's care. The policy must address the facility's responsibility to document the coordination and oversight with the third party providers and the administrator's specific role in the coordination of care within the facility. The facility must implement a written log for all residents receiving care from any third party providers. The log must include, at a minimum, name of resident who is receiving care, the name of the third party provider who is providing the care, and documentation of any care services and

treatments completed including the course of the progress of care/ services rendered to the resident. This requirement must be completed by .

Please be advised that nothing in this Directed Plan of Correction limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact Laura Manville, Assisted Living Enforcement Team Manager at 727-552-1955 or Tikel Wedges-Phoenix, Assisted Living Supervisor at 561-381-8540.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure
XG90