STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968286	**12/19/2017**
NAME OF PROVIDER OR SUPPLIER **CHRISTALLIS MANOR, CORP.**	STREET ADDRESS, CITY, STATE, ZIP CODE **2119 WILSON STREET HOLLYWOOD, FL 33020**	

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

0000 - Initial Comments

A Limited Nursing Service (LNS) monitoring visit was conducted on at Christallis Manor, Corp., License #12232. The facility had deficiencies at the time of the visit.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, interview and record review the Assisted Living Facility (ALF) failed to ensure form 1823 resident assessments were updated to reflect changes in condition for 2 of 2 residents identified as having a change in condition, Resident #1 and Resident #2. As evidenced by failing to update the 1823 for Resident #1 when re-admitted to the ALF with a ; and failing to update the 1823 for Resident #2 when admitted to hospice services.

The findings included:

1) Resident #1 was admitted to the ALF on .
On at 2:40 PM upon entering the ALF, Resident #1 was observed sitting in the living a leg drainage bag in open view. An interview with Resident #1 regarding the was attempted, however, he was unable to provide any information related to when and why a was in place.

On at 3:15 PM an interview was conducted with the ALF owner Registered Nurse (RN) inquiring about the to which she stated the resident was sent out to the hospital and returned to the ALF with the , however, she could not provide an explanation for the reason for the . She did state a home health agency is looking after the and it was last changed around and the resident's physician did not want it discontinued just yet, reasons unknown. On at approximately 3:45 PM a request was made to the owner RN for the home health records, to which she replied the home health comes in daily however they do not leave a record of their visits in the ALF.

Review of Resident #1's record revealed no evidence of documentation when, why or where the resident was transferred to; there was no physician order to transfer the resident to the hospital; there was a brief observation note dated , written by the owner RN, stating the resident was discharged from the hospital with a and the case manager at the hospital submitted orders for home health for care; there was no order for the or any other physician orders pertaining to the ; there were no orders for home health services; there were no ALF progress notes relating to any assessment or monitoring of the by ALF staff. Further review of the resident's record revealed the latest 1823 resident assessment form was dated . There was no evidence of a

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current 1823 resident assessment updating the resident's change in condition to reflect he now has a

2) Resident #2 was admitted to the ALF on . On at 3:00 PM Resident #2 was observed in her bed with in place at 3 and a half liters via nasal cannula. An attempt was made to interview the resident however she was very and could barely open her eyes. An interview was conducted with Resident #2's sibling, Resident #3 who also resides in the facility, who stated Resident #2 is now receiving hospice services.

On at 4:00 PM an interview was conducted with the ALF owner Registered Nurse (RN) who stated they sent the resident to the hospital prior to the recent hurricane in , 2017 and while there her condition deteriorated and when she was readmitted to the ALF she was admitted to hospice services. The owner RN could not state when the resident was readmitted to the facility. Review of Resident #2's record revealed no documentation related to the resident going out to the hospital and no documentation related to her return to the ALF. Review of the hospice folder revealed Resident #2 was admitted to hospice on . Further review of the resident's record revealed the latest 1823 resident assessment form was dated . There was no evidence of a current 1823 resident assessment updating the resident's change in condition to reflect her now being on hospice and on continuous .

Class III

0031 - Resident Care - Third Party Services - 58A-5.0182(7) FAC

Based on observation, interview and record review the Assisted Living Facilty (ALF) failed to ensure communication was maintained between home health agencies and the ALF for 2 of 2 residents reviewed receiving home health agency services, Resident #1 and Resident #3. As evidenced by the ALF failing to communicate with the home health agency for Resident #1 related to care and management; and failed to communicate with the home health agency for management for Resident #3.

The findings include:

1) On at 2:40 PM upon entering the ALF, Resident #1 was observed sitting in the living a leg drainage bag in open view. An interview with Resident #1 regarding the was attempted, however, he was unable to provide any information related to when and why a was in place.

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Review of Resident #1's record revealed no evidence of documentation when or why the was inserted. Review of a brief observation note dated , written by the ALF owner RN, documented the resident was discharged from the hospital with a and the case manager at the hospital submitted orders for home health for care. Further review of the record revealed there was no order for the or any other physician orders pertaining to the ; there were no orders for home health services; there were no ALF progress notes relating to any assessment or monitoring of the by ALF staff.

Review of Resident #1's Medication Observation Record (MOR) revealed an order for injections and sugar checks twice daily with the notation "home health nurse", with no evidence of documentation these services were being performed.

On at 3:15 PM an interview was conducted with the ALF owner RN inquiring about the to which she stated a home health agency is looking after the and it was last changed around by a home health nurse. A request was made to review the home health records related to the and sugar monitoring and administration to which she stated they do not have those records as the home health nurse does not leave a record in the facility.

2) Review of the MOR for Resident #3 revealed was ordered twice daily in addition to sugar checks ordered once daily with a notation "home health nurse" with no evidence of documentation of the administration of the or sugar recordings. Review of the resident's record revealed no evidence of documentation related to managment.

On at approximately 3:45 PM a request was made to the ALF owner RN for the home health records for Residents #3 related to management, to which she replied the home health nurse comes in daily however they do not leave a record of their visits in the ALF. An inquiry was made about the sugar results and if they are controlled for Residents #1 and #3, to which she stated she was not sure. An inquiry was made how the facility staff communicates with third party vendors and vice versa, to which the ALF owner RN stated it has been a problem and one that needs to be rectified.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on interview and record review the Assisted Living Facility (ALF) failed to ensure Medication Observation Records (MOR) were complete and accurate for 6 of 6 resident MORs reviewed. As evidenced by failing to document assistance with medications was provided for residents #1, #2, #3, #4, #5, and #6.

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The findings included:
On at approximately 3:30 PM, the MORs for 2017 were reviewed for the 6 residents to reveal the following:
1) Resident #1 - 3 medications due at 8 PM on were already signed off as administered.
was ordered twice daily in addition to sugar ordered twice daily with a notation "home health nurse" with no evidence of documentation of the administration of the or sugar recordings.

2) Resident #2 - 7 medications due at 8 AM on were not signed off as administered.
1 medication due at 5 PM on was not signed off as administered and 3 medications due at 8 PM on were not signed off as administered.
1 medication ordered twice daily was blank from with no indication in the record the reason the medication was not administered.
1 medication ordered twice daily was blank from with no indication in the record the reason the medication was not administered.
An order for a breathing treatment to be administered every 4 hours was blank for the month of with no indication in the record the reason the medication was not administered.

3) Resident #3 - 12 medications due at 8 AM on were not signed off as administered.
1 medication due at 12 PM on was not signed off as administered.
3 medications due at 8 PM on were not signed off as administered.
was ordered twice daily in addition to sugar ordered once daily with a notation "home health nurse" with no evidence of documentation of the administration of the or sugar recordings.

4) Resident #4 - 2 medications due at 8 PM on were already signed off as administered before they were due to be administered.

5) Resident #5 - 1 medication due at 8 AM on was not signed off as administered.
2 medications due at 8 PM on were not signed off as administered.

6) Resident #6 - 1 medication due at 8 AM on was not signed off as administered.
2 medications due at 8 PM on were not signed off as administered.
An ointment with directions apply twice daily to affected area with no indication where the affected area was located.

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On at approximately 3:45 PM an interview was conducted with the owner Registered Nurse (RN) apprising her of the omissions on the resident's MORs. The owner RN stated the only explanation she had was the medication technician who was present in the ALF this morning had to attend a class and must have been distracted and did not sign off the MORs this morning. A request was made to the owner RN to provide documentation from the home health agency for Resident #1 and Resident #3 to confirm the was being given and sugars monitored. The owner RN was unable to produce this documentation stating the home health agency does not leave a chart in the ALF.

Class III

0189 - ADCCs in ALF - FS 429.905 (2); 58A-6.013 (2-3) FAC

Based on observation and interview, the Assisted Living Facility (ALF) failed to maintain a record of services provided for 1 of 1 residents the ALF identified as being a day care resident only, Resident #7, as evidenced by no documentation available for review.

The findings include:

On at 2:40 PM, upon entering the ALF, 7 residents were observed sitting in the living . At this time an inquiry was made to the ALF aide how many residents were currently living in the facility to which she replied 6. An inquiry was made why there were 7 residents sitting in the living which she had no reply.

Review of the ALF license, effective through , documented the facility capacity to be 6.

On at 2:45 PM a telephone interview was conducted with the ALF owner Registered Nurse (RN) who confirmed there are 6 residents residing in the facility and the 7th resident did not live there and was only a day care resident.

On at 2:50 PM a tour of the facility was conducted with the ALF aide. It was confirmed Resident #1, the only male, had a single occupancy one bed. Residents #2 and #3 shared a one single bed each. Resident #4 and #6 shared a one single bed each and Resident #5 had a single one bed for a total of 6 beds available for use by the 6 full time residents. The ALF aide confirmed there was no bed for the 7th resident in the event the resident wished to nap or rest in private.

On at approximately 3:00 PM the ALF owner RN arrived to the facility and again confirmed the 7th resident is a day care resident and is brought by a family member in the morning around 7 AM and

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picked up in the evening between 6-7 PM. The ALF owner RN confirmed the resident was provided meals and assisted with toileting. The ALF owner RN stated the resident has been coming here for about a year. A request was made to the ALF owner RN for any documentation, contract, assessment, consents related to the resident care and services being provided for the 7th resident, to which the owner RN stated they do not have any documentation of that nature.

On at 4:15 PM the 7th resident's family member arrived to the facility to drop something off and stated she would return later to take the 7th resident home with her. An interview was conducted with the family member at this time who stated the resident has been coming here for about a year now and she brings her in the morning and picks her up in the evening. An inquiry was made if the resident has any special dietary needs to which she stated she is a and on a low sugar diet however the resident tends to eat what she wants. She stated she checks her sugar in the morning before she brings her here and gives her her . An inquiry was made if the resident requires any medications during the day while she is here, to which she stated she prepares a pill organizer every few days and leaves it with the staff and the staff here provide assistance with her medications. The ALF owner RN confirmed at this time they assist the resident with her medications when she is here.

On at 4:30 PM a request was made again to the ALF owner RN for any documentation related to the 7th resident to which she stated they do not have any documentation and did not think it was necessary if the resident did not live here.

Class III

N276 - LNS - Nursing Services - 58A-5.031(1) FAC

Base on observation, interview and record review, the Assisted Living Facility (ALF) failed to identify and appropriately assess 1 of 1 residents identified as qualifying for Limited Nursing Services (LNS), Resident #1. As evidenced by failing to document the care of a for Resident #1.

The findings included:

Review of the ALF license effective through , documented the ALF has a standard license in addition to LNS.

Upon entry to the ALF on at 2:40 PM, Resident #1 was observed with a leg drainage bag in plain view.

On at 2:45 PM a telephone interview was conducted with the ALF owner Registered Nurse

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(RN), who when asked if they have any residents requiring LNS, stated they do not.

On at 3:00 PM the ALF owner RN arrived to the ALF and again confirmed they do not have any residents who qualify for LNS. An inquiry was made who is assessing and monitoring Resident #1's to which the ALF owner RN stated a home health agency. An inquiry was made when and why Resident #1 had a inserted to which the ALF owner RN stated the resident was readmitted to the ALF from the hospital with the and she was not sure why he had the . The ALF owner RN stated a home health nurse comes daily to assess the . A request was made to review the home health records related to the to which she stated they do not have those records as the home health nurse does not leave a record in the facility.

Review of Resident #1's ALF record revealed no physician orders for the or care of the ; no orders for home health services and no ALF progress notes relating to any assessment or monitoring of the by ALF staff.

Review of the LNS Agreement, signed , revealed the ALF owner RN is the designated person responsible for overseeing LNS in this facility.

On at approximately 4:00 PM the ALF owner RN stated she has not implemented the LNS program as yet because she was waiting on the ALF Consultant, who has been ill, to tell her what she needs to do. Review of the ALF license revealed the facility has been licensed for LNS since .

Review of the ALF Policy for Limited Nursing Service documents - the following services may be provided under the limited nursing service license to include , , , care and maintenance.

Class III