STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910997	**12/29/2017**
NAME OF PROVIDER OR SUPPLIER **NIGHTINGALE MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **1753 MICHIGAN AVENUE** **MIAMI BEACH, FL 33139**	

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

0000 - Initial Comments

A Complaint Survey (CCR#2017014134) was conducted on , 2017 and concluded on , 2017. Nightingale Manor (AL#4687) had deficiencies identified at the time of the survey:

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, record review, and interviews the facility failed to provide adequate supervision for 26 sampled residents (Residents #1-26). Resident #1 was found unresponsive in the hours after the last time he was seen by the only staff working the night shift.

Findings included:

During a tour of the facility on between 9:15 AM and 9:35 AM observed that the facility had two buildings that were connected by a patio, there were 10 residents in the front building and 16 residents in the second building.

A review of the adverse incident report showed that Resident #1 was found unresponsive on at 5:20 AM in the his pants down siting on the toilet with a syringe in his hands by another resident. The report stated that the last time staff saw him was at midnight. The report further stated emergency medical service ( ) removed Resident #1 from the performed , , ( ), but the resident was pronounced .

A review of the the medical examiner office's report on documented Resident #1 tested positive for (main metabolite of), , and .

A review of the staffing schedule for the months of , and the month of revealed that there was only one staff working during the 4:00 PM to 12:00 AM and 12:00 AM to 8:00 AM shifts to supervise 26 residents. The facility did not make any changes to staffing related to supervision after Resident #1 was found at the facility. The facility provided a drug and policy, however they did not provide any evidence that residents were screened or that staff were trained regarding the policy.

A review of the health assessments revealed 15 residents had a diagnosis of , Type, three had diagnosis of , three had diagnosis of , three are , three have diagnosis of and six are . Resident # 11 required assistance with all of his activities of daily living.

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The health assessment for Resident #1 dated revealed the resident had a diagnosis of , Low (there was another ineligible diagnosis). His medications were 30 mg one capsule daily, , , 100 mg one tablet twice a day, 50 mg 2 tablets three time a day, , 600 mg one tablet every 8 hours, , , 50 mg one tablet every 8 hours, 20 mg one tablet at bedtime and , 100 mg half a tablet at bedtime.

Record review found the facility did not have any progress notes documenting when Resident #1 was found unresponsive on . The Administrator's Assistant stated on at 11:45 AM that the incident had been report on the incident report website. He then looked in the office and brought a sticky yellow note that stated what had happened to the resident.

On at 10:05 AM the Administrator's Assistant stated Resident #1 used to live in # and that when they found him there was a needle close to him and apparently he used drugs. He also stated that the resident was a young guy and he did not know that he had any history of using drugs.

On at 11:10 AM the Administrator's Assistant stated that Staff C was working that day and found him and called 911. She stated that was started by the rescue and that Staff C did not initiate the . The rescue arrived 5 minutes after Staff C called. "I can't say why she did not initiate ," he stated. He further stated at 11:15 AM that the resident did not have a ( ).

On at 2:12 PM Staff C stated on the phone, "I saw Resident #1 about one at night and he was talking to me. He put food in the microwave and ate when I was moping the floor. When I finished moping I made a round and he was inside his the door closed about 4 am. His friend called him and did not answer, he opened the door and found him on the toilet and called me and I called the ambulance. I did not make , I called 911 and they came. I make rounds all the time, I open the door to see the resident."

On at 2:33 PM Resident #10 stated, "I knocked on the door of his he did not answer and I left. I came back about 40 minutes later about 5 or 5:30 in the morning and knocked again and he did not answer. I had the urge to use the when I opened the I found him with his pants down sitting on the toilet leaning forward with a syringe in his hand and he was blue."

On at 2:40 PM the Administrator's Assistant stated, "There is only one staff at night because the building is not that big and they are all independent. I come in at six in the morning."

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On at 12:05 PM the Administrator's Assistant stated, "Some of the residents let us know where they go but others not. We do not accept residents that are not able to go out on their own."

On at 12:23 PM the Administrator's assistant stated, "We have never had any residents that use or drugs. Resident #1 was never seen under the influence of drugs or ."

On at 2:28 PM Resident #7 stated, "There is only one lady working at night, she does not make rounds at night. If I need anything I go to the kitchen where she is. Resident #1 was nice when he came in but them he started to be with the wrong people and started to use drugs."

On at 2:30 PM Resident #21 stated, "I have been living here since 2003. I am able to go in and out but not later than eight at night. We do not have to tell them where we go."

On at 2:50 PM Resident #20 stated, "There is one person at night and she does not go in the ."

On at 2:52 PM Resident #9 stated, "There is usually one person working at night. Sometimes she goes inside the . We all look out for each other. I saw Resident #1 a day before he and he was fine. I heard he was using drugs before he . He was getting out of control when he used drugs."

On at 2:55 PM Resident #24 stated, "There is one person at night. She does not go in the ."

On at 2:58 PM Resident #4 stated, "There is only one person at night. They never come into the check. I saw Resident #1 when he was , the police was taking his body out of here."

On at 3:01 PM Resident #2 stated, "I have been living here for 10 years. They check on me before I go to bed but not during the night. Resident #1 was my during the hurricane. They said he was using drugs. I was around when he and I went to get the housemother but he was already ."

During a phone interview on at 1:05 PM Participant E stated, "I was the person who handled his veteran's benefits. I do not know where he was living before living at that facility, I believe he was on the streets. I was involved because he had a long history of drug . I am not sure that the facility knew about it. I had to find a place for him to live. I believe he from a heroin overdose."

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Phone interview on at 11:50 AM Resident #10 stated, "I knocked on Resident #1's door because the night before we were up until late at night and he had invited me over if I wanted to come to his . I did not have any idea that he was going to relapse. I woke up early and started pacing and went and knocked on his door. That was the second time; I had called the paramedics a month before on him; I found him on the floor turning blue; we saved his life and when he came back from the hospital he punched me in my eye for calling the paramedics."

Class II

0051 - Medication - Pill Organizers - 58A-5.0185(2) FAC

Based on observation, record review, and interview the facility failed to ensure that a nurse manage a pill organizer for a resident that self administers medications for 1 of 27 sampled residents (Resident #16).

Findings included:

On at 9:28 AM observed a pill organizer with medications inside on top of the dresser of Resident #16 in # .

Review of the health assessment for Resident #16 revealed the resident is able of self-administer medications.

On at 9:31 AM the Administrator's assistant stated he prepared the pill organizer for the resident when the resident comes to the office and that he is not a nurse. He also stated that he will let his wife who is a nurse prepare the pill organizer.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview the facility failed to ensure that a resident that self-administers medications maintain the medication in a safe manner. The facility also failed to ensure that all medications were labeled with the name of the resident.

Findings included:

During tour of the facility on at 9:28 AM, observed on the window in # occupied by Residents #16 and #17 a bottle of Concentrate (labeled), a labeled bottle of , , a

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labeled bottle of D 2000 units, a labeled bottle of power, a labeled tube of Ointment, a unlabeled bottle of Fish Oil and a unlabeled bottle of Mega Green Tea Extract. Also, a pill organizer with medications inside was observed on top of the dresser.

The Administrator's assistant stated on at 9:29 AM that Resident #16 self-administers the medications and does not give them back to him. He also stated that he will put a lock in one of his drawers so that he can keep them in his will make sure that the medications are labeled with his name.

Class III

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Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on record review and interview the facility failed to have the signed attestation of compliance in the employee record for 12 of 12 sampled employees (#1-12).

Findings included:

Review of the employee records for Staff #1-12 revealed the facility did not have signed attestation of compliance forms in their records.

On at 12:37 PM the Administrator's assistant stated that if that was new and if he could print the form out of the AHCA website.

Unclassified

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review and interview the facility failed to keep the employment status of all employees within the clearinghouse for 1 of 12 employees (Staff L).

Findings included:

Employee record revealed Staff L was hired by the facility on .

On at 1:53 PM the Administrator's assistant stated Staff L was the janitor.

Unclassified

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c) FS

Based on record review and interview the facility failed to ensure that staff that had a break-in-service of more than 90 days from a position that required a level II background screening before being employed by the facility for 2 of 12 employees (Staff J and M).

Findings included:

Review of the employee record of Staff J revealed the staff member was hired by the facility on . Staff J's level II background screening was dated . The facility did not have the employment history on Staff J's application from the date her background was completed to the date she

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was hired.

On at 1:15 PM the Administrator's assistant stated, "Staff J was unemployed." At 1:25 PM he stated, "She will probably be terminated because she called out 2 weeks ago."

Review of the employee record of Staff M revealed staff was hired by the facility on . Staff M's level II background screening was completed on . The facility did not have the employment history on her application from of 2014 to the date she was hired.

On at 1:58 PM the Administrator's assistant acknowledged Staff M did not have any employment history on her application after 2014 until the date she was hired at the facility.

Unclassified