STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953664	**06/10/2019**
NAME OF PROVIDER OR SUPPLIER **MIDWAY MANOR RETIREMENT RESIDENCE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1754 ENSLEY AVENUE** **CLEARWATER, FL 33756**	

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

0000 - Initial Comments

Assisted Living

A Complaint Investigation (Complaint Number: 2019006360 and 2019006371) was conducted at Midway Manor Assisted Living Facility on . Deficiencies were identified at the time of survey.

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

Based on observations, record reviews, and interviews, the Facility failed to provide care, services, and personal supervision as appropriate to meet the needs of resident accepted for admission to the Facility for three Residents (#1, #2, and #9) of three sampled residents.

Findings Included:

Observations of Residents #1, #2, and #9, conducted on , revealed that Residents #1, #2, and #9 were wheelchair bound. At 04:10pm, Resident #2 had a room and bathroom that appeared unclean/filthy (See Photographic Evidences3 and 4). At 04:25pm, Resident #1 and #9's shared room and bathroom appeared unclean/filthy (See Photographic Evidence2).

A record review for Resident #1, conducted on , revealed that Resident #1 had a Health Assessment Form dated and had diagnoses and history of left sided due to a , , , and . Resident #1's Health Assessment Form did not include the type of assistance that the resident required for ambulation and bathing. Resident #1's progress notes dated stated that the resident was "officially discharged today". As the resident was residing at "the Pinellas County jail and they have arranged for his stay elsewhere". Resident #1 was re-admitted on . The Facility did not obtain a new -to- Health Assessment for Resident #1 upon re-admission. There were many documented instances from through regarding Resident #1's drunk and intoxicated behaviors, inappropriate behaviors such as yelling, cussing, hitting, and throwing objects at both residents and staff, and repeated and hospitalizations due to intoxication. Upon re-admission, Resident #1's progress notes documented that the resident's behaviors continued. There were no care and services described in Resident #1's record to meet the resident's need for cessation or continued uncontrollable behaviors. On , Resident #1 and the resident's roommate, Resident #9, got into an argument and [Resident #9] said that Resident #1] hit [Resident #9] twice in the ". There were no care and services implemented to keep resident #9 safe from Resident #1. Resident #1 and #9 continued as roommates on the date of survey . On at 03/20am, Resident #1 "slid out of" the wheelchair and when staff went to check on the

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resident, the resident "was on the floor passed out" and let the resident "sleep it off" and the resident continued drinking "all day" and again in which paramedics were called to get the resident off the floor. On , the Facility "called cops due to [Resident #1 was] very intoxicated and threating to hurt me and pull my hair and again". On , Resident #1 " out of wheelchair [and the resident] was drunk". There was no documented evidence that Resident #1's Health Care Provider was notified of the resident's excessive drinking.

A record review for Resident #2, conducted on , revealed that Resident #2's Health Assessment Form dated stated that the resident was independent with all Activities of Daily Living and wheelchair bound. There were no care and services described on page five of Resident #2's Health Assessment Form to meet the needs of the resident's unclean behavior. There were no entries in Resident #2's progress notes since which stated that the "housekeeper tried to clean [the resident's] room [and] found rotten banana and an old onion with gnats flying around in room [and that the room smelled] really bad even after being cleaned".

Interviews with Residents #1, #2, #3, #7, #8, and #9, conducted on , revealed that the Facility did not provide housekeeping services to meet the needs of Residents #1 and #2's unclean behaviors. At 10:10am Residents #3 stated that the Facility provided housekeeping services to resident rooms and bathrooms once per week. At 10:20am Residents #7 stated that the Facility provided housekeeping services to resident rooms and bathrooms once per week. At 10:30am, Resident #8 stated that "no housekeeping comes in". At 04:10pm, Resident #2 stated that "no, they do not do anything (in regards to housekeeping)". At 04:25pm, Resident #9 stated that "they cleaned it (room and bathroom) today" and come in "once a week". At 04:30pm, Resident #1 stated that "no" the Facility did not provide housekeeping.

A review of the Facility's Residency Agreement, conducted on , revealed that the Facility agreed to provide "residents with a comfortable and sanitary room as well as the basic services". The Facility's Residency Agreement in Section 16.2 stated that resident's medication "will not be dispensed should the Med Tech on duty suspect the resident has consumed and will inform your Primary Care Provider should the Facility believe the resident to be in excessive drinking".

A review of the Housekeeping Policy and Procedure, conducted on , revealed that the Facility deems "housekeeping an important role to the Facility as this department is how the resident lives in a clean kept environment".

During an interview with the Administrator, conducted on at 03:00pm, the Administrator stated that Resident #1 was issued a forty-five-day notice of discharge on . The document was not

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provided. At 04:35pm, during a walkthrough observation of Residents #1 and #9's shared room, with the Administrator, the Administrator agreed that Residents #1 and #9 room and bathroom did not appear as though it had been cleaned that day. At 05:45pm, the Administrator was unable to provide documented evidence of care and services arranged to meet Resident #1's needs for cessation or continued uncontrollable behaviors.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on observations, interviews, and record reviews, the Facility failed to honor resident rights by failing to provide a safe, clean, and decent living environment for residents residing in the Facility.

Findings Included:

During an observation of Staff D and E, conducted on at 09:30am, Staff D was loudly reprimanding Staff E in the dining room with two female residents and another staff member present. Surveyor could hear Staff D from outside of the dining room door.

During an observation of Resident #2's room and bathroom, conducted on at 04:10pm, Resident #2's room and bathroom appeared unclean/filthy (See Photographic Evidence3 and 4). The carpet was filthy and stained. There was food (possibly cereal) dumped on the floor by the bed. There was a foul odor present. The bed mattress was open/uncovered. There was garbage and clutter throughout. Resident #1's machine and items on the nightstand had a substance consistent with mold. Resident #1's tubing and tubing appeared discolored and old. The bathroom floor, sink, toilet, shower, and shower curtain were visibly dirty. The toilet had no toilet seat. The sink cabinet was cracked/broken in several places (See Photographic Evidence3 and 4). The resident was wheelchair bound.

During an observation of Resident #1 and #9's shared room and bathroom, conducted on at 04:20pm, Resident #1 and #9's room and bathroom appeared unclean/filthy. The carpet was filthy and stained. The bathroom floor, sink, toilet, shower, and shower curtain were visibly dirty (See Photographic Evidence2). The air temperature was 84 degrees Fahrenheit. There were no windows open. There was no fan present. The air was uncomfortably muggy. Residents #1 and #9 were both wheelchairs bound.

During an observation of Residents #4 and #10's shared room, conducted on , revealed that Residents #4 and #10 room had no air conditioning functioning. The air temperature was 84 degrees

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Fahrenheit. There were no windows open. There was no fan present. The air temperature was uncomfortably muggy.

During an interview with Resident #7, conducted on [redacted] at 10:10am, Resident #7 stated that the Facility provided housekeeping services once every week to clean the resident's room and bathroom.

During an interview with Resident #3, conducted on [redacted] at 10:20am, Resident #3 stated that the Facility provided housekeeping services once every week to clean the resident's room and bathroom.

During an interview with Resident #8, conducted on [redacted] at 10:30am, Resident #8 stated that "no housekeeping come in" to clean the resident's room or bathroom".

During an interview with Resident #2, conducted on [redacted] at 04:10pm, Resident #2 stated that "no, they don't do anything (referring to housekeeping services)" (See Photographic Evidence3).

During an interview with Resident #9, conducted on [redacted] at 04:18pm, Resident #9 stated that the staff had "no experience on what to do" and that staff won't move Resident #1 from the room. Resident #9 stated that the resident was "staying at my girlfriend's house because I don't want to be around that (referring to the resident's roommate's drinking)". Resident #9 stated that housekeeping came in and cleaned the resident's room and bathroom "today" and that the housekeeper comes in "once a week". Resident #9 stated that the air condition unit was "out all weekend" and that they were "fixing it now". Resident #9 stated that staff did not offer the resident to move to another room, open a window, or offer a fan while the air conditioning unit was broken.

During an interview with Staff H, conducted on [redacted] at 04:20pm, Staff H stated that the air condition unit had been "down since Saturday ([redacted])" [and] I only found out this morning and called the repair man". Staff H stated that the air conditioning affected two apartments, Residents #1 and #9's apartment and Residents #4 and #10's apartment.

During an interview with Staff B, conducted on [redacted] at 11:35am, Staff B stated that the housekeeper cleans resident rooms and bathrooms Monday through Friday. Staff B stated that "the caregiver do the cleaning and laundry" when the housekeeper was off.

During an interview with Staff E, conducted on [redacted] at 03:15pm, Staff E stated that the staff felt like there was "no guidance over the weekends and no one in charge". When questioned how the staff was treated by management, Staff E did not want to respond and stated that "some days are better than other". Staff E stated that the care staff "try to pitch in" with housekeeping services.

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During an interview with Staff D, conducted on [redacted] at 03:30pm, Staff D apologized to the Surveyor on reprimanding Staff E in front of residents and other staff and stated that "it should have taken place behind closed doors".

During an interview with resident #1, conducted on [redacted] at 04:21pm, Resident #1 stated that staff provided care and services inconsistently and did not provide housekeeping services. Resident #1 stated "no" when asked if staff offered the resident another room, a fan, or to open a window when the air conditioning stopped working.

A record review for Resident #1, conducted on [redacted], revealed that Resident #1's progress notes stated that on [redacted], Resident #1 was discharged from the Facility due to incarceration at the Pinellas County jail. On [redacted], Resident #1 returned to the Facility "drunk with a bottle of rum [and] cussing out staff [and] refusing to leave the property as directed". On [redacted], Resident #1 threw beer bottles at Staff E. On [redacted], Resident #1 hit Resident #9 (roommate) in the [redacted] twice. The police officer that arrived suggested that the two residents should "stay away from each other". On [redacted], Resident #1 had "been very drunk all night and starting fights [with roommate Resident #9 and took Resident #9's] shoes and will not return". On [redacted], staff called the cops on Resident #1 "due to [the resident was] very intoxicated and threating to hurt me and pull my hair". There were many documented instances from [redacted] in which Resident #1 was drunk/intoxicated, displayed inappropriate behaviors such as yelling, cussing, and hitting residents and staff, and had many [redacted] and hospitalizations due to intoxication. Residents #1 and #9 continued as roommates on the day of survey [redacted].

A record review for Resident #2, conducted on [redacted], revealed that Resident #2's progress notes dated [redacted] stated that the housekeeper "tried to clean [the resident's] room and found rotten banana and an old onion with gnats flying around in room [and that the resident's room smelled] really bad even after being cleaned".

A review of timeanddate.com for the location of the Facility, conducted on [redacted], revealed that the high temperature for [redacted] was 85 degrees. The high temperatures for both [redacted] and [redacted] was 90 degrees.

During an attempt to review the Department of Health Annual Inspection, conducted on [redacted], the requested document was not provided during survey.

A review of the Housekeeping Policy and Procedure, conducted on [redacted], revealed that the Facility considered "housekeeping [as] an important role to the Facility as this department is how the resident

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lives in a clean kept environment". The Housekeeping Policy and Procedure described the weekly cleaning tasks of each resident's room that were supposed to be performed, which included cleaning lobby and apartment by:

- Sweeping/vacuuming/mopping the floor and cleaning air vents
- Assuring the walls were clean and free of debris
- Checking rooms and areas to make sure there are no holes in the wall
- Checking all fixtures in the rooms and lobby area to make sure they are working properly and the light bulbs in each fixture are enough for the room
- Assuring there was toilet paper with two extra roles
- Changing the bed linen and assuring the mattress and box springs were in good condition
- Assuring that no clothes were on the floor lying around
- Checking the closet area and making sure the closet area is tidy
- Checking all furniture and making sure furniture was clean and free of dirt
- Cleaning the air vents and assuring that no dust was around it
- Cleaning windows and sills
- Assuring that the room had no offensive odors and the carpet was cleaned

There were no provisions in the cleaning schedule for the cleaning of bathrooms and checking functionality and maintenance of bathroom fixtures and cabinets.

A review of the Facility's Residency Agreement, conducted on . . . . . , revealed that the Residency Agreement stated that "the Facility agrees to provide the residents with a safe, comfortable, and sanitary room as well as the basic care services".

During an interview with the Administrator, conducted on . . . . . at 04:45pm, the Administrator stated that there were two female beds and two male beds vacant and available that staff could have moved Residents #1, #4, #9, and #10 when their air conditioning unit was not working. The Administrator agreed that Residents #1 and #9's room and bathroom were not clean. The Administrator stated that the Facility allocated funds each month for carpet replacement but the money this month had to go to the replacement of the washing machine. The Administrator stated that there was no carpet replacement schedule in place. At 03:00pm, stated that the housekeeper was gone for a week and that "care staff took over housekeeping" while the housekeeper was off. The Administrator stated that the Facility's Administration were paid salary and over the weekends were on-call". The Administrator was unaware that Resident #2 did not have a toilet seat and stated that the resident's mattress was not one that the Facility provided. The Administrator stated that the Facility issued a 45-day notice to Resident #1 on . The Administrator agreed that Staff D should not have reprimanded Staff E in front of residents and staff and stated that it should have been done "private and no in front of residents and other staff". The Administrator did not provide requested documents for the Department of Health

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Inspection Report or Resident #1's 45-day notice. The Administrator agreed to fix the current cleanliness and broke fixtures issues with Residents #1, #2, and #9's rooms and stated that the Facility would develop a plan to put in place for carpet replacement.
Class III

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

Based on record review and interview, the Facility failed to ensure Medication Observation Records (MORs) were accurate and free from errors for one Resident (#5) of one sampled resident who required assistance with self-administration of medication.

Findings Included:

A review of Resident #5's MORs, conducted on , revealed that Resident #5's MORs had the resident's prescribed 1000microgram/milliliter injection signed as given every day from through by unlicensed Medication Technicians.

During an interview with Staff B, conducted at 02:00pm, Staff B stated that Resident #5's Home Health Nurse comes into the Facility and administers the resident's prescribed injections.

During interviews with the Administrator, conducted on at 03:00pm and 05:45pm, the Administrator agreed that Medication Technicians should not have signed Resident #5's as given.
Class III

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

Based on observations, record reviews, and interviews, the Facility failed to provide central storage of medications when one Resident (# 2) failed to maintain prescribed and over-the-counter medications in a safe manner and failed to dispose of a discontinued medication within thirty days of the medication's discontinuation for one Resident (#5) of two sampled residents.

Findings Included:

Observations of the medication (med) cart for Resident #2 and Resident #5, conducted on , revealed that:
- Resident #2 had a med bubble pack that was untouched dated , . There were no meds for Resident #2 for .

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- Resident #5's discontinued . . . . , . . 0.3% . , ... Solution continued in the med cart.

An observation of Resident #2's room, conducted on . . . . . at 04:10pm, revealed that Resident #2 was unsafely managing prescribed and over-the-counter meds and medical equipment. Resident #2 had meds that were on top of the night stand, in the night stand drawer, and on the window sill. The surfaces that the meds were lying on were unclean/filthy. Resident #2's . , . . . , ... machine had areas with brownish discoloration, to the filter area and the tube insertion holder, consistent with mold (See Photographic Evidence4).

During an interview with Resident #2, conducted on . . . . . at 04:10pm, Resident #2 stated that "I do my own meds". Resident #2 stated that "they don't do anything" with the resident's meds and that "I took my meds over because they were always out of my meds".

A record review for Resident #2's, conducted on . . . . . , revealed the Resident #2's Health Assessment Form dated stated that Resident #2 required assistance with self-administration of meds. The care and services that the Facility described on page five of Resident #2's Health Assessment Form to meet the needs of the resident for assistance with self-administration of meds was for the Facility to provide "medication management". There were no orders or an assessment in Resident #2's record that the resident was capable of self-administer meds or able to safely manage meds. Resident #2's . . . . . Medication Observation Records (MORs) had signatures of unlicensed Medication Technicians that stated that medications were "given by self".

A review of Resident #5's , and MORs, conducted on , revealed that Resident #5 had no orders for . . . . , . 0.3% . , . . . Solution for , and . . . . . .

A review of the Facility's Medication Policy and Procedure (Med P&P), conducted on . . . . . , revealed that the Facility's Med P&P stated that the "Facility will provide assistance with self-administration of meds by an unlicensed professional for all residents". The Med P&P stated that, "the Facility will not allow any residents to keep any meds including over-the-counter meds, in the resident's room without explicit order by the Primary Care Provider".

During an interview with the Administrator, conducted on . . . . . at 03:00pm and 05:45pm, the Administrator agreed that Resident #2 needed med management and that the Facility should have disposed of Resident #5's . . . . , . . . , ... Solution.
Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

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Based on observations, record reviews, and interviews, the Facility failed to provide medications (meds) consistent with Health Care Provider's orders for five Residents (#2, #3, #5, #6, and #9) of five sampled residents who required assistance with self-administration of meds.

Findings Included:

A review of the Facility's Residency Contract, conducted on , revealed that the Facility with residents to provide the services of coordinating with the Pharmacy to make the meds available at the Facility for the residents.

A review of the Facility's Medication Policy and Procedure (Med P&P), conducted on , revealed that the Facility's Med P&P stated that the "Facility will provide assistance with self-administration of meds by an unlicensed professional for all residents". The Med P&P stated that, "the Facility will reorder the meds for all residents under medication management". The Med P&P stated that, "if the resident has to leave the Facility with friends and/or anyone else, the resident has the choice to take the meds with them".

During an observation of the med pass with Staff B for Resident #3, conducted on at 11:00am, Staff B provided Resident #3 with , 5mg which was in the resident's med bubble pack. Resident #3 had an order for 10mg three times every day. Staff B did not notice this until the Surveyor brought it to the staff's attention.

Interviews with Residents #2 and #9, conducted on , revealed that the Facility did not provide or reorder meds as prescribed. At 04:10pm, Resident #2 stated that "I took my meds over because they were always out of my meds". At 04:25pm, Resident #9 stated that the resident prescribed was out "since four days ago [and] I can't sleep".

During an interview with Staff B, conducted on at 11:35am, Staff B stated that "usually we do" have the meds available for residents.

A record review for Resident #5, conducted on , revealed that the Facility did not provide Resident #5's meds or provide oversight when the resident refused meds. Resident #5's Health Assessment Form dated required assistance with self-administration of meds. Resident #5's Medication Observation Records (MORs) had the residents prescribed meds 10mg and , 400mg documented as not given to the resident for various dates and times for reasons described as the resident "did not come down to med room", "resident refused", "too strong for [the resident]", and "[the resident] only takes this at night". Resident #5's MORs had the residents

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prescribed meds 10mg documented as not given to the resident from through for reasons described as the resident "resident refused" and "[the resident] only takes this at night". There was no evidence provided that Resident #5's Health Care Provider and Responsible Party were notified that the resident was not taking the prescribed meds.

A record review for Resident #6, conducted on , revealed that the Facility did not provide Resident #6 with medication administration or medications as prescribed. Resident #6's Health Assessment Form dated stated that the resident required medication administration. There were no care and services described on page five of Resident #6's Health Assessment Form to meet the needs for medication administration. Resident #6's MORs had the prescribed meds 15mg and , 5mg, , , and , were documented as not given for reasons as "out of Facility" and "did not come down for meds to the med room". There was no evidence provided that Resident #6's Health Care Provider and Responsible Party were notified that the resident was not taking the prescribed meds.

During an interview with the Administrator, conducted at 01:45pm, the Administrator stated that the Medication Technicians "should have caught this error before today" had the Medication Technician compared the med label with their MORs when assisting Resident #3 with meds. At 03:00pm and 05:45pm, agreed that the Facility did not provide Resident #5 and #6 with meds as ordered or make the meds available when the residents were away from the Facility. The Administrator unable to provide evidence that Residents #5 and #6's Health Care Providers and Responsible Parties were notified that the residents did not receive their meds as prescribed.
Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the Facility failed to obtain evidence of a negative ( ) examination from a Health Care Provider that was documented on an annual basis for one employee (Staff A) of three sampled staff.

Findings Included:

A record review for Staff A, conducted on , revealed that Staff A's record did not include annual evidence that the Staff A was free from signs and symptoms of , from a Health Care Provider annually. The last negative Screening was documented on .

During an interview with the Administrator, conducted on at 05:45pm, the Administrator agreed

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that Staff A's record did not include evidence that the staff was free from signs and symptoms of since .
Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC 429.52 (6), FS

Based on observation, record review, and interview, the Facility failed to provide proof that one unlicensed employee (Staff B) completed the required six-hours of Assistance with Self-Administration of Medications and Medication Management Training prior to assisting residents with medications.

Findings Included:

During an observation of the medication pass, conducted at 11:10am and 11:20am, Staff B was observed assisting Residents #3 and #4 with medications.

A review of Staff B's employee record, conducted on , revealed that Staff B had a certificate of completion for Medication Administration Assistance dated (See Photographic Evidence1). The certificate did not include the number of training hours completed or the required training elements as described in Rule 58A-according to 5.0185, Florida Administrative Code. Staff B was hired on .

During an interview with the Administrator, conducted on at 05:45pm, the Administrator agreed that Staff B's Medication Administration Assistance Training certificate was not the six-hour required training for unlicensed Medication Technicians.
Class III