Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969267	A. BUILDING: _____ B. WING _____	01/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERLY R US LLC	2980 NW 84 TERR MIAMI, FL 33147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (complaint number 2022000340) was conducted at Elderly R Us LLC on to . Deficiencies were identified at the time of survey.	A 000		
A 007 SS=D	59A-36.006(1) FAC Admissions - Criteria (1) ADMISSION CRITERIA. (a) An individual must meet the following minimum criteria in order to be admitted to a facility holding a standard, limited nursing services, or limited mental health license: 1. Be at least . 2. Be free from signs and symptoms of any communicable that is likely to be transmitted to other residents or staff. An individual who has ( ) may be admitted to a facility, provided that the individual would otherwise be eligible for admission according to this rule. 3. Be able to perform the activities of daily living, with supervision or assistance if necessary. 4. Be able to transfer, with assistance if necessary. The assistance of more than one person is permitted. 5. Be capable of taking medication, by either self-administration, assistance with self-administration, or administration of medication. a. If the resident needs assistance with self-administration of medication, the facility must inform the resident of the professional qualifications of facility staff who will be providing this assistance. If unlicensed staff will be providing assistance with self-administration of medication, the facility must obtain written informed consent from the resident or the resident's surrogate, guardian, or attorney-in-fact. b. The facility may accept a resident who requires	A 007		

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A 007	Continued From page 1 the administration of medication if the facility employs a nurse who will provide this service or the resident, or the resident's legal representative, designee, surrogate, guardian, or attorney-in-fact, contracts with a third party licensed to provide this service to the resident. 6. Not have any special dietary needs that cannot be met by the facility. 7. Not be a danger to self or others as determined by a health care practitioner, or a mental health practitioner licensed under Chapter 490 or 491, F.S. 8. Not require 24-hour licensed professional mental health treatment. 9. Not be bedridden, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S.; 10. Not have any or 4 , . A resident requiring care of a may be admitted provided that: a. The resident either: (I) Resides in a standard or limited nursing services licensed facility and contracts directly with a licensed home health agency or a nurse to provide care; or (II) Resides in a limited nursing services licensed facility and care is provided by the facility pursuant to a plan of care issued by a health care practitioner; b. The condition is documented in the resident's record and admission and discharge logs; and, c. If the resident's condition fails to improve within 30 days as documented by a health care practitioner, the resident must be discharged from the facility. 11. Residents admitted to standard, limited nursing services, or limited mental health licensed facilities may not require any of the following nursing services:	A 007		

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A 007	Continued From page 2 a. [illegible] airway management of any kind, except that of continuous positive airway pressure may be provided through the use of a CPAP or bipap machine; b. Assistance with [illegible], c. Monitoring of [illegible] gases, d. Management of post-surgical drainage tubes and [illegible] vacuum devices; e. The administration of [illegible] products in the facility; or f. Treatment of surgical [illegible] or [illegible], unless the surgical [illegible] or [illegible] and the underlying condition have been stabilized and a plan of care has been developed. The plan of care must be maintained in the resident's record. 12. In addition to the nursing services listed above, residents admitted to facilities holding only standard and/or limited mental health licenses may not require any of the following nursing services: a. [illegible], and [illegible], performed in the facility; b. [illegible], performed in the facility. 13. Not require 24-hour nursing supervision, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S.; 14. Not require skilled rehabilitative services as described in Rule 59G-4.290, F.A.C. 15. Be appropriate for admission to the facility as determined by the facility administrator. The administrator must base the determination on: a. An assessment of the strengths, needs, and preferences of the individual; b. The medical examination report required by Section 429.26, F.S.; c. The facility's admission policy and the services the facility is prepared to provide or arrange in order to meet resident needs. Such services may not exceed the scope of the facility's license	A 007		

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A 007	Continued From page 3 unless specified elsewhere in this rule; and, d. The ability of the facility to meet the uniform fire safety standards for assisted living facilities established in rule Chapter 69A-40, F.A.C. (b) A resident who otherwise meets the admission criteria for residency in a standard licensed facility, but who requires assistance with the administration and regulation of portable [illegible] or assistance with routine [illegible] care of [illegible] site [illegible] placement, may be admitted to a facility with a standard license as long as the facility has a nurse on staff or under contract to provide the assistance or to provide training to the resident on how to perform these functions themselves. (c) Nursing staff may not provide training to unlicensed persons, as defined in Section 429.256(1)(b), F.S., to perform skilled nursing services, and may not delegate the nursing services described in this section to certified nursing assistants or unlicensed persons. This provision does not restrict a resident or a resident's representative from [illegible] with a licensed third party to provide the assistance if the facility is agreeable to such an arrangement and the resident otherwise meets the criteria for admission and continued residency in a facility with a standard license. (d) Not withstanding any other provisions of this rule, an individual enrolled in and receiving licensed hospice services may be admitted to an assisted living facility pursuant to Section 429.26(1)(d), F.S. (e) Resident admission criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility	A 007		

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A 007	Continued From page 4 admitted an individual that did not meet the minimum criteria for admission to an assisted living facility for one out of four sample residents (Resident #2). Finding include: A review of the facility Admission and Discharge Log on [redacted], it showed that Resident #2 was admitted to the facility on [redacted] and was discharge on [redacted]. The reason for the discharge was that the resident pass way. A review of Resident #2 Health Assessment dated [redacted], it showed that the examining nurse practitioner (ARNP) mark "yes" to the following questions: 1. A communicable [redacted], which could be transmitted to other residents or staff? 2. Bedridden? 3. Any [redacted], 3, or 4, [redacted]? 4. Pose a danger to self or others? In an interview with Administrator on [redacted] at 10:05 AM, regarding the health assessment, the Administrator stated that she never questions the information that was included in the health assessment with the examining physician. Class III	A 007		
A 054 SS=E	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing	A 054		

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A 054	Continued From page 5 pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an accurate and up to date Medication Observation Record (MOR) for two out of four sample residents (Resident #1 and Resident #2). Finding Include: A review of Resident #1 MOR for [illegible] to [illegible], it showed the MOR was missing the following information: resident [illegible], and the physician's name and telephone number.	A 054		

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A 054	Continued From page 6 A review of Resident #2 MOR for the month of [illegible], it showed that the MOR was missing the following information: physician name and telephone number, resident [illegible], and the direction of use for each medication ([illegible], 100 mg and [illegible], 5 mg). In an interview with Staff A on [illegible] at 1:00 PM, Staff A acknowledge that the MOR for Resident #1 and Resident #2 were missing the information. Class III	A 054		

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A 000	Initial Comments A complaint investigation (complaint number 2022000340) was conducted at Elderly R Us LLC on to . Deficiencies were identified at the time of survey.	A 000		
A 011 SS=G	59A-36.006(5) FAC Admissions - Discharge (5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or health care practitioner, the resident must be discharged in accordance with Section 429.28, F.S. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to discharge one of four sampled residents (Resident #1) when the resident no longer met the criteria for continued residency. Resident #1 became bed bound, developed , , and was not enrolled in hospice care. The resident declined for eight days, developing slurred speech and left-sided and before being transferred to the hospital. Findings: A review of Resident #1's Health Assessment dated showed that the resident had a medical history and diagnosis of , , with , diverticulosis of with risk of , , , , fragility due to in childhood. The resident was also diagnosed with physical or Sensory limitations: generalized , unsteady gait with High Risk of , . The resident's /behavioral status showed: memory loss, forgetful, disoriented and . The resident	A 011		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 011	Continued From page 1 needed medication management by RN (registered nurse), and ALF (assisted living facility) care. The resident needed precautions and precautions. The resident needed assistance with ambulation, bathing, eating, grooming, and transferring. The resident required total care with toileting. As for medications, the resident needed assistance with self-administration of medications. The health assessment also indicated that the resident did not have any , 3, 4 and the resident was not bedridden. A review of Resident #1's Observation Log dated showed that the resident was removed from hospice care. It stated, "The hospice physician considers that the resident does not meet the necessary criteria to continue with the care. The resident general health has improved. She ambulates with assistance." A review of Resident #1's Observation Log dated showed, "The resident feels weak, difficulty with eating, it takes a lot of effort to ambulate. The resident primary care provider (Nurse Practitioner) was notified of the situation." A review of Resident #1's Observation Log dated showed that the resident appetite has improved but is having difficulty with ambulation and she feels weak. A review of Resident #1's Observation Log dated showed that in the morning during bathing, the staff noticed that the resident had a on the , are on both heels. The resident primary care provider was notified. A review of Resident #1's Observation Log dated	A 011		

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A 011	Continued From page 2 . . . . . showed that Resident #1 was seen by her primary care provider. The note stated, "The provider order repositioning the resident every 2 hours, but this is difficult due to the resident's advance . . . . . He also advises of the possibility of placing the resident on hospice care due to declining health and the need of increase nursing services. The provider will follow-up with the resident in one week." The note showed that the provider also ordered the following medications: 1. , 2% apply to affected area twice a day for 10 days 2. Silver 1% cream apply to area twice a day. Further review of the log showed that the resident's medical provider (Advanced Practice Registered Nurse- APRN) stated on various occasions that the resident's skin was fragile due to age and a history of . . . from the waist down when she was an adolescent. A review of Resident #1's Observation Log dated . . . . . showed that the Assistant Administrator contacted the resident's son, and she communicated the criteria of the APRN to place the resident under hospice care. The log stated that the resident's son refused hospice placement. A review of APRN Progress Notes dated . . . . . for Resident #1 showed that the chief complaint was , on , heels and calcaneus area. The notes stated 'The physician recommended to Resident #1's son that the resident must be evaluated by hospice care. Her son refused. ALF staff continues to mobilize the resident every 2 hours. A. General: the patient is awake in no apparent	A 011		

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A 011	Continued From page 3 distress, appropriate, pleasant, and . . . , ... on the , heels, and calcaneus areas. The resident is completely bed bound. B. Skin: , ... on the . . . . , heels, and calcaneus areas. No broken skin, no bad odor, no discharge, no painful to touch. Pink and warm with good . No . . . . . C. Plan: This case was discussed with Dr. [ ] because patient has risk of , ... due to , body , , and . . . . . , even though she walks with difficulty and is frequently mobilized by ALF staff. care done today by APRN. Reinforce to staff the necessity of continue mobilization of patient every 2 hours. The resident was order . . . . . 2% cream and Silver 1% ." A review of the Nurse Practitioner Progress Notes dated . . . . . showed: "1. Subjective: patient is visited today at the ALF because of , ... on the . . . . , ... heels and calcaneus area. . follow-up. She continues with . . . . . , orientated x 2, forgetful, walk using devices and with assistance, and . . . . . , no . . . , she is partial bed bound. ALF staff continue to mobilize the patient frequently. Skin need continue observation to avoid progression of the problem. . . . . care was performed. 2. Objective: Skin- , . . on . . . . . , ... heels and calcaneus areas. No bad odor, no discharge, not painful to touch, no rashes. Pink and warm with good skin . . . No . . 3. Plan: A. care- clean with normal solution, , . dry, and applied . . . . . 2% was done by APRN using sterile	A 011		

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A 011	Continued From page 4 techniques. B. Follow up in 48 to 72 hours by the physician. C. Refer to the . . . . care if the condition worsens. D. Reinforce to staff the necessity to continue mobilized patient every 2 hours E. Apply medications as ordered." A review of Resident #1's Observation Log dated showed that the APRN went to see the resident. The log stated that . . . . care was done, and it was ordered that the resident be repositioned every 2 hours. It also stated that 'this type of is common due to the resident been partially bed bound.' Finally, it stated that the was closed. A review of Resident #1's Observation Log dated . . . . . showed that the resident was weak and did not have the strength to get out of bed. It was also reported that the resident had slur speech and . . . on the left side of the body. 911 was called. Resident was transfer to the local hospital. A review of Resident #1's Observation Log dated . . . . . showed the resident's son called the facility to inform that the resident was not returning. The resident was discharge from the facility on . In an interview on at 10:00 AM, Staff C stated that Resident #1 was send to the hospital because she was not feeling well. The resident's son then decided not to return the resident to the facility. In an interview with the Assistant Administrator on . . . . . at 10:05 AM, she stated that Resident #1 only had a " " in the . area. The	A 011		

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A 011	Continued From page 5 area ( ) was not open. There were no , in any part of the body. At the present time, the resident was not under hospice care. She was disenroll from hospice on by the hospice provider. As for the skin, Staff A stated that the resident had a history of below the waist and that the skin was very delicate. Staff A also stated that she notified the resident primary care provider as soon as was noticed. On , the resident was received an order to reposition the resident every 2 hours. Finally, Staff A stated the PCP came to the facility to do care and the resident was transfer to local hospital on due to "possible ". The resident was discharge from the facility on because the son took the resident out of the facility per Staff A. In an interview with the Assistant Administrator on at 10:10 AM, she stated that Resident #1's primary care provider contacted the resident's son about placing the resident on hospice. The son refused. The Assistant Administrator stated that she was thinking of placing the resident in a nursing home, but no notice was given to the resident legal guardian regarding the potential discharge from the facility. The Assistant Administrator stated that the resident would sit in the recliner and later move to her bed, and that the staff would get her up to walk for dinner. As for care, she stated that the resident's primary care provider saw Resident #1 on and . The Assistant Administrator stated that was not open, and that care cream was applied to the area. In an interview with Resident #1's family member on at approximately 10:00 AM, regarding Resident #1 hospice placement, the	A 011		

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A 011	Continued From page 6 complainant stated no, I was not told to place Resident #1 in hospice, no body have talk to me. He also stated that he notices the [redacted] on [redacted]. He stated that he tried to notify the Assistant Administrator of the condition, but she stated "do not bother me. I am on vacation". Finally, he stated that he wanted his mother out of the facility. In an interview on at 10:32 AM, Staff B (caregiver) stated that Resident #1 would be place in a recliner during a portion of the day. She stated, "When sitting in the recliner, I would put a pillow under her." Staff B further stated that occasionally, the resident with assistance of staff would ambulate. Regarding the , Staff B said, "I would apply both creams to the [redacted] area and the heels". Staff B stated that there was no [redacted] or pus present on the [redacted]. Finally, Staff B stated she could not tell if the skin was open or close. Further review of Resident #1's observation log found no documentation that the resident was provided with a 45-day notice of discharge after the physician recommended hospice care and the facility documented that the resident's son refused this level of care. Class II	A 011		
A 054 SS=E	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription	A 054		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969267	A. BUILDING: _____ B. WING _____	01/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERLY R US LLC	2980 NW 84 TERR MIAMI, FL 33147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 054	Continued From page 7 number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an accurate and up to date Medication Observation Record (MOR) for two out of four sample residents (Resident #1 and Resident #2). Finding Include: A review of Resident #1's MOR for to showed the MOR was missing the following information: resident , and the	A 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 054	Continued From page 8 physician's name and telephone number. A review of Resident #2's MOR for the month of , it showed that the MOR was missing the following information: physician name and telephone number, resident , and the direction of use for each medication (, 100 mg and , 5 mg). In an interview on at 1:00 PM, the Assistant Administrator acknowledged that the MOR for Resident #1 and Resident #2 were missing the information. Class III	A 054		