STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910713	02/05/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
New Hope Group Home	6021 Duval Street Hollywood, FL 33024	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - L243 - 58a-5.0191(8) Fac - Lmh - Training S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced complaint inspection survey (CCR# 2013011151) was conducted on [redacted] at New Hope Group Home. The facility had licensure deficiencies found at the time of the visit.

Note: Complaint inspection survey (CCR#2013011151) was conducted in conjunction with the relicensure revisit survey on the same date. Please refer to the separate report for findings.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observations, record review and interview, the facility failed to provide care and services appropriate to the needs of residents accepted for admission to the facility, for 7 of 7 sampled residents (Resident #1-#7). As evidenced by facility failure to provide supervision appropriate for each resident, specifically at night between the shift of 6 PM and 6 AM.

The findings include:

A) During an interview on [redacted] at approximately 9:00 AM with Employee #1, she stated she is the housekeeper and she is at the facility alone. She stated she works 2 hrs a day from 8:30 AM-10:30 AM. She stated she does not pass medications and the administrator usually gets in at 10:30 AM. She also stated that from 5:00 PM (after dinner), they do not eat until morning but they get a big dinner. A staffing schedule was observed posted on the wall dated [redacted] 2013, there was no current schedule for the month available.

The Administrator arrived at the facility at 9:50 AM on [redacted] A copy of staffing schedule was requested. The Administrator provided a scheduled for the month of [redacted] 2014. The scheduled was reviewed with the Administrator at 10:15 AM on [redacted] Review of the staff schedule with the Administrator revealed she was documented to work on noted day from 6 AM-12 PM, she stated she was running late. The Administrator stated she was also responsible for assisting the residents (Resident #1-#7) with their medications for that morning. However, she once again revealed she was "running late". Review of the medication observation records (MORs) did not identify any of the 7 residents had received their 7 AM medications.

Further review of the [redacted] 2014 staffing pattern schedule, revealed the night shift (6 PM to 6 AM) for the month was staffed by either Employee #3 or Employee #2. Review of the schedule revealed Employee #3 was scheduled to work the prior night [redacted] During an interview with the Administrator at 10:25 AM on [redacted] regarding who worked at the facility last night and to request an interview with them; she stated they are not available because the father is in the hospital. The Administrator at this time, did not say who was covering for the employee.

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During an interview at 11:20 AM on ..... with Employee #2 (direct care giver), he stated the Administrator comes to the facility anytime between 7 AM and 10 AM ; she does not have a set schedule. He further stated " At night we do not stay here (at the facility) we are next door, if there is a problem they can come next door to get us". He stated after 9 or 10 nobody sleeps here. He stated , that in the past there may have been 1 or 2 incidents where residents have gone out at night but not often. Employee #2 was questioned at this time, regarding the supervision at the facility and how they provide supervision to the residents if they are not present in the facility. Employee #2 was unable to state how they supervise the residents at night and confirmed that the scheduled staff (Employee #2 and #3) do not stay in the house with the residents overnight. He stated they (Employee #2 and #3) are relatives of the Administrator who live in the house next door to the facility

During the interview with the Administrator on , she stated she does not have any policy regarding supervision of the residents. She also stated she does not have a sign in or out sheet, letting them know where residents are going or when they leave. The Administrator also stated "When an emergency comes they call me on my cell phone and somebody comes to take care of them. She stated her sister and brother-law (her sister's husband) and 2 kids live next door; they work the night shift; "they are not physically in the building but will come over if needed".

B) During random interviews with the residents between the hours of 9 AM and 2 PM on , the following was revealed.

1) During an interview at 9:20 AM on ..... with Resident #1, he stated he was living at the facility about 3 years. He stated the other day he went for walk for a bag of potato chips because he was hungry. The resident was observed very ..... and unable to answer most questions. The resident was unable to provide any additional information about the facility.

2) Resident#2 was observed during the survey conducted on , the resident was observed wearing dirty clothes. An unsuccessful attempt was made to interview the resident on , it was very hard to communicate with the resident as the resident had a speaking .....

3) During an interview at 11:10 AM with Resident #3, he stated he works at the gas station picking up boxes. He stated he hears voices in his head and was unable to provide any information about what goes on in the facility. He stated he stays at the gas station all morning and day sometimes comes home at midnight. He also stated he has a beer once in a while to get the troubles off his mind; he drinks behind the gas station. During the survey, the resident was observed sitting at the table cursing and becoming belligerent.

4) During an interview at 11:10 AM on ..... with Resident # 4, he stated he was hanging out at the mall and there is nowhere else to go so he goes back and forth about three times a day. He stated people at video store give me a couple of bucks every once in a while to get cigars, soda and coffee. "Nobody is here at night after 7 PM or 8 PM; any problems we call the police".

5) During an interview at 9:40 AM on ..... with Resident #5, he stated the Administrator comes in at 10:30

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AM and the people who live next door take care of things at night (relatives of the Administrator, 2 males and a female). If there is a problem we have to go next door and for an emergency we call 911.

6)During an interview at 10:00 AM on with Resident #6 (sitting outside smoking), she stated she has no idea how long she has been here. She stated, "At night I think someone next door has a key to the house" she did not know who the neighbors were. The resident did not know, if she had breakfast or took her medications today and could not provide any additional information about the facility. Observation at 11:30 AM on of Resident #6, revealed the resident was walking around a house full of men in her bra and pants; mumbling to herself and answering the phone that was not ringing.

7) During an interview at 9:45 AM on with Resident #7, he stated he has been living at the facility for about 3 years. He stated the Administrator comes in about 10:30 AM and leaves about 6:30 PM. If any problems at night we have to go next door or for an emergency we call 911.

C) During observations of the residence of Employee #2 and #3 (night staff), it was noted the property is not on the grounds of the facility. The property is adjacent to the facility located to the right and separated by a parameter fence. Further observations revealed the residents would have to walk off the grounds of the property (exit the facility), walk along a sidewalk about approximately 15 feet to reach the location of the night staff (their place of residence). Since, the residents have to physically leave the facility at night for assistance; this exposes them to all the outside weather elements and any other hazards at night. Please also refer to Resident #1 to #7's medical diagnosis. (Photographic evidence obtained)

D) On at 10 AM, resident records were reviewed; the following was noted.

1) Review of Resident #1's record revealed an admit date of to the facility. Resident #1's Health Assessment (AHCA form 1823) dated documents the resident's diagnosis as and Further review of the assessment revealed page 2 of the form is missing. A second health assessment was located within the resident's file dated documented diagnosis was listed as history of and Chronic Undifferentiated and medication monitoring. A mental health provider agreement dated was located within the resident's file, the agreement documents the following services to be provided to the resident; assist and supervise medications, assistance with personal hygiene, behavioral problems and appointments.

2) Review of Resident #2's record revealed an admit date of Resident #2's Health Assessment (AHCA form 1823) with no date, documents the resident's diagnosis as and unsteady Gait. The form documents the resident needs assistance with all ADLs. Further review of the form failed to list any medications for the resident. However, the form documents the resident requires medication administration; goes to program for medications.

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3) Review of resident #3's record revealed an admit date of to the facility. Resident #3's Health Assessment (AHCA form 1823) dated documents the resident's diagnosis as The form documents skilled nursing for psych med's. The form documents the resident is independent with ambulation, dressing, and transferring and requires supervision with bathing eating and toileting. Further review of the form documents the resident needs assistance with medications; followed by home health services to stabilize status within limitations. A mental health provider agreement dated was located within the resident's file, the agreement documents the following services to be provided to the resident; need to to arrange programs to socialize with other people, medication management teach relaxation techniques.

4) Review of Resident #4's record revealed an admit date of to the facility. Resident #4's Health Assessment form (AHCA form 1823) dated documents the resident's diagnosis as , forgetful and agitated. The form documents the resident as independent with all ADLs and requires supervision with eating and dressing. The form also documents the resident needs assistance with medications. A mental health provider agreement dated was located within the resident's file, the agreement documents the following services to be provided to the resident; the need to identify and discuss thought perception and feelings recognize and develop effective coping skills teach new ways to reduce

5) Review of Resident #5's record revealed an admit date of to the facility. Resident #5's Health Assessment form (AHCA form 1823) dated documents the resident's diagnosis as include and . Further review of the form documents the resident is independent with all Activities of Daily Living (ADLs) and requires supervision with eating. The form also notes the resident requires assistance with medications. A mental health provider agreement dated was located within the resident's file, the agreement documents the following services to be provided to the resident; monitor resident's well being and supervise medications.

6) Review of Resident #6's record revealed an admit date of to the facility. Resident #6's Health Assessment form (AHCA form 1823) dated documents the resident's diagnosis as Remission, and choking precautions. Further review of the form documents the resident is independent with all ADLs. The form also documents the residents needs assistance with medications. A mental health provider agreement dated was located within the resident's file, the agreement documents the following services to be provided to the resident; need to supervise medications and to assist to identify disturbing thoughts.

7) Review of Resident #7's record revealed an admit date of to the facility. Resident #7's Health Assessment form (AHCA form 1823) dated documents the resident's diagnosis as Mental forget full and disoriented. The form documents the resident is independent with all ADL and requires assistance with monitor his eating/nutrition. A mental health provider agreement dated was located with the resident's file. However, record review revealed the resident does not have a case worker or go to program; the resident no longer receives LMH services.

E) Review of Resident #1's file revealed a note indicating that on at 12:00 PM, Resident #1 walked out of

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the yard, law enforcement was called to report a missing person; law enforcement called back to report that the resident was found and was at the hospital. Resident #1 returned to facility on at 2:00 PM. Resident #1 at 8:00 PM , began screaming at a female resident (Resident #6) and choked her, the Administrator "rescued her, called rescue, police and rescue personnel came". Resident # 1 was taken to hospital where he was . A review of the involuntary forms revealed the resident was due to violent behavior; the resident attempted to choke a resident at the Assisted Living Facility. The form documents the resident's diagnosis as: , Behavioral and .

A record review of the Hospital Behavioral Health Psychosocial Assessment Update Note dated for Resident # 1, revealed the following. Resident #1's current diagnosis includes:
a) Axis I-
b) Axis II-Deferred
c) AxisIII- , Behavioral
d) Axis Primary Support group problems, Social and Environmental problems and Housing Problems
e) Axis V- 11-20: Some danger of hurting self and others, possible or occasionally fails to maintain minimal personal hygiene or gross in communication.
The current living situation is addressed and states that per Assisted Living Facility (ALF) staff and resident's family member, the resident is not allowed to return to the ALF due to violent outburst. According to the family member the Resident's Case Manager is working to identify a facility that offers a higher level of care. The hospital Discharge Plan dated revealed that Resident #1 was discharged back to the ALF he came from.

In an interview conducted with the Administrator on at approximately 2:00 PM , she stated that on Resident #1 was placed under a and spent 7 days in the hospital for his behaviors and the incident involving another resident. She also stated that the resident has been given a 45 day notice of discharge, due to him requiring a higher level of care and that his case manager has been advised and that they are looking for a new placement for him. A request for a copy of the 45 day notice was made and upon review of the notice, it was noted the notice was a handwritten document dated stating the following. "I am giving you 45 days notice. You can leave the facility as soon as possible because of your behavior". As of the resident still resides at the facility. The Administrator stated they cannot find a place to put him.

F) During telephone interviews on with the residents' Case Managers, the following was revealed.

1) At approximately 3:00 PM on a telephone interview with the Case Manager for Resident #1 and #2, the following was revealed. She stated Resident # 1 has behavioral issues and requires supervision at night. She stated she has been his case worker for the last 2 years; they are trying to find another facility for this resident because he is low functioning and requires supervision. She stated Resident #2 is unable to communicate clearly. She also stated Resident #2 is low functioning and should not be left alone. She further stated that she was unaware of the lack of supervision at night.

2) At approximately 3:15 PM on a telephone interview with the Case manager for Resident #4 and # 6, the following was revealed. She stated she was not unaware the these residents were left alone at night. She stated Resident #4 can be left alone, unsupervised. However, Resident #6 is not able to be left alone without

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supervision.

3) At approximately 11:23 AM on , a telephone interview with the Case Manager Supervisor, she stated they have been trying to move Resident #1 since . She stated he . . through the cracks and is known to have violent behaviors and needs to be kept on medications. She further stated she was not aware there was no staff in the facility in the evening.

4) At approximately 11:50 AM on . . . . at 11:50 AM, a telephone interview with the Case Manager for Resident #3, the following was revealed. She stated she was not aware residents are left alone at night. She had the understanding that an ALF is supposed to have supervision 24/7 and that is the reason the resident was placed there.

The facility failure to ensure appropriate supervision is provided to the residents at the facility during the 6 PM and 6 AM shift, directly threatens the physical, emotional health and safety of the residents residing at the facility.

Class II

L243-LMH - Training 58A-5.0191(8) FAC
Based on record review and interview, the facility failed to ensure staff, who have direct contact with residents in a licensed limited mental health facility receive the required training, for 1 of 3 sampled employee' s (Employee #1).

The findings include:

Review of Employee #1 (date of hire , revealed the file did not contain the required documentation of the completion of 6 hours of specialized training in working with individuals with mental health diagnoses. Further interview with the Administrator revealed Employee #1 is left alone in the facility and has direct contact with the residents . The Administrator confirmed Employee #1 did not have aforementioned training.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
New Hope Group Home
6021 Duval Street
Hollywood, FL 33024

RE: CCR #2013011151 and Relicensure Revisit Survey

Dear Administrator:

This letter reports the findings of a complaint inspection survey and a relicensure revisit survey conducted on 5, 2014, by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, State (5000-3547) Form, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this hand delivered report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0079 - 58a-5.019(4) Fac - Staffing Standards - Levels S-S= D
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D
St - A - L243 - 58a-5.0191(8) Fac - Lmh - Training S-S= D

Directed Corrective Actions:

1. The Assisted Living Facility is required to ensure that a staff member is present at the facility (on grounds) at all times, reflecting 24 hour staff coverage.

2. The Assisted Living Facility is required to develop and maintain an accurate monthly staffing schedule, reflecting the daily staffing pattern for each staff member. This schedule should reflect a 24 hour staffing pattern.

3. The Assisted Living Facility is required to ensure that all staff members receive a minimum of 6 hours of specialized training in working with individuals with mental health diagnoses.

4. The Assisted Living Facility is required to evaluate all current residents (Resident #1-#7) to ensure continued residency criteria is met and that the facility is able to meet the care needs of each resident (including supervision).

3. The Assisted Living Facility is required to discharge any resident that no longer meets the continued residency criteria immediately.

4. The Assisted Living Facility is required to complete an adverse incident report for Resident #1 (incident that occurred on and submit to the Agency.

5. The Assisted Living Facility is required to develop and establish a monitoring plan to ensure all adverse incidents are properly evaluated (documented) and required documents submitted to the Agency within the required timeframe (1 adverse incident report & 15 day adverse incident report).

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

Should you have any questions, please call Catherine Anne Avery, Survey and Certification Support Branch at (850) 412-4505 or Tikel Wedges-Phoenix, Health Facility Evaluator Supervisor at (561) 381-5846.

Sincerely,

T. Wedges-Phoenix, Supervisor

Arlene Mayo-Davis
Field Office Manager

MD/ls
Enclosure

Received by: Rebecca Thomas Adm.
Administrator/Representative Title

Date Hand Delivered: 3/11/2014