STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963868	09/25/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Oasis Home For The Elderly	33 West 26 Street Hialeah, FL 33010	

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

List of Tags Cited:
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= J
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0079 - 58a-5.019(3) Fac - Staffing Standards - Levels S-S= D
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= C

Specific Tag Findings:

0000-Initial Comments

A Complaint Investigation survey (CCR #2014009432) was conducted on to . Oasis Home for the Elderly had deficiencies found at the time of the survey.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on record review and interview, the facility failed to honor resident rights by providing adequate and appropriate health care. The facility failed to administer ( ) for 1 out of 3 sampled residents (Resident #1). The failure of the facility staff to perform in the absence of a ( ) places all residents of the facility, who do not have a , at immediate risk of harm.

The findings included:

Review of the facility's one day adverse incident report documented Resident #1 committed by hanging himself outside the facility on at 5:30 AM.

Review of Resident #1's record documented, he was admitted to the facility on . He was diagnosed with Major (MDD). The health assessment dated documented, he was independent with ambulation and transfer and required assistance with bathing, dressing, and toileting. The record did not contain a ( ). The facility's policy documented, the facility will inquire, prior to admission, whether the resident has a . Based on record review, the facility did not have any documentation showing that resident #1 had a .

During interview on at 11:02 AM with Staff A, she stated that Resident #1 was a very quiet person and did not have a lot of communication with the staff and residents. She stated, he asked her for permission to go to the Lodge on Thursday, / . He told her, today might be the last time that I go to the Lodge. Staff A reported, we have two staff working all night. The staff does facility rounds at night. Staff A reported, I worked the night shift on . She did not observe Resident #1 in his bed on at 4:30 AM. She reported, I thought he was in the I did not go look for him. A few minutes later, Resident #2 told me that Resident #1 was sitting on the porch, near the walkway in a plastic chair looking onto the street. She reports, she saw him sitting in that place many times before. When she went to open the porch's walkway door she found Resident #1 hanging from that door at about 5:30 AM. She touched his body and he was warm. Based on the interview, she did not check for resident #1's pulse, she did not cut the shoe laces from where resident #1 was hanging, or initiate . She contacted 911 immediately and the facility's administrator. Staff A reported, she did not remember anything else because she was very nervous. She reported, the police and investigators found that Resident #1 hung himself using his shoe laces.

During interview on at 11:32 AM with Staff B (caregiver), she stated that they conducted three or four rounds at night. During her rounds on at 5:00 AM, she did not observe Resident #1 in his bed. She

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checked outside the facility and saw him sitting at the front of the porch's walkway door. Staff A went outside to open the porch's walkway door and a few minutes later found Resident #1 hanging from the door. Staff A called 911 immediately. She reported, I continued touring the facility. She reports, I did not go outside to see Resident #1's condition, I did not see him.

During interview on at 10:58 AM with the facility's administrator, she stated, she received a phone call from Staff A on at about 6:00 AM. Staff A informed her, Resident #1 committed . He used an ornamental iron fence which is the door at the left side of the porch's walkway to hang himself. Staff A contacted the police and his family members. The staff told me that Resident #1 played Dominoes and Chess until 9:15 PM the night before the incident. His friends visited him frequently. He did not show any symptoms of at any time. She stated, "We do not understand why he did that."

During interview on at 12:10 PM with Resident #2, he stated, he goes outside the facility during the night two or three times to smoke. He stated, "I saw a man sitting in a plastic chair looking at the street at 5:00 AM." He reported, Resident #1 resided in the facility for a short time.

Based on record review and interviews, it was determined the facility failed to initiate to resident #1 after he was found hanging by shoe laces outside the facility. The facility staff who found resident #1 touched his body and found that it was still warm, yet failed to check for a pulse or call for assistance by the other staff member who was present. The facility's staff members working on left resident #1 hanging from the fence door. The facility staff did not cut the lace shoes attached to resident #1's neck, check for a pulse, and administer ( ).

Class I

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

Based on record review and interview, the facility failed to maintain accurate time sheets for all the staff.

The findings included:

Observation on at 9:00 AM documented that Staff A, Staff B, and Staff E were providing personal services to residents. Staff D was in the kitchen preparing lunch for the residents. Staff I was not in the facility.

Review of the facility's time sheets for documented that Staff B was off and Staff I started to work at 7:00 AM. Record review found that the facility's time sheets were not accurate based on the personnel working during the survey.

Review of the facility Staffing Pattern for 2014 showed that Staff A worked from 7:00 AM-6:00 PM with Wednesday's off, Staff B worked from 7:00 AM-6:00 PM with Saturday's off, Staff C worked from 6:00 PM-7:00 AM with Monday's off, Staff D worked from 7 AM-7 PM with Thursday's off, and Staff E worked from 7 AM-6 PM with Sunday's off. Staff I was not on the staffing schedule.

During interview on at 12:10 PM with Resident #2, he stated, he received assistance from Staff A, B, D and E. He reported, Staff H is my friend and she is not working here at the facility anymore. He never received any assistance from Staff I.

During interview on at 12:40 PM with Resident #3, he stated, he received assistance from Staff A,

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Staff B, Staff D, and Staff E. He reported, Staff H does not work in the facility anymore. He reported, Staff I is not a facility staff person.

During interview on at 1:45 p.m. with Resident #4, he stated that Staff I is Staff G's sister and she does not work here at the facility. He reported, Staff I sometimes visits the facility to spend time with Staff G, but she never provide services to any resident. He said, Staff H does not come to the facility anymore, for over a month.

During interview on at 12:02 PM with the administrator, she stated, the staff schedule can be change internally by the staff because they have been working in the facility for many years together. She reports, Staff H is an on-call staff, and Staff I was hired a month ago and works at night.

Class III

0079-Staffing Standards - Levels 58A-5.019(3) FAC

Based on observation, record review, and interview, the facility failed to maintain an accurate written work schedule which reflects its 24-hour staffing pattern for a given time period. The facility failed to maintain the minimum of 253 staff hours per week for a census of 18 residents.

The findings included:

Observation during the facility tour on at 9:00 AM showed Staff B was interacting with residents and providing assistance with activities of daily living and Staff I was not in the facility.

Review of the facility time sheets for showed that Staff B was off and Staff I started to work at 7:00 AM. The facility needed to maintain a minimum of 253 hours for 18 residents. According to facility record review, the facility had 242 hours for the week instead of the required 253 hours.

Review of the facility Staffing Pattern for 2014 showed that Staff A worked from 7:00 AM-6:00 PM with Wednesday's off, Staff B worked from 7:00 AM-6:00 PM with Saturday's off, Staff C worked from 6:00 PM-7:00 AM with Monday's off, Staff D worked from 7 AM-7 PM with Thursday's off, and Staff E worked from 7 AM-6 PM with Sunday's off. Staff I was not on the staffing schedule.

During interview on at 12:10 PM with Resident #2, he stated, he received assistance from Staff A, B, D and E. He reported, Staff H is my friend and she is not working here at the facility anymore. He never received any assistance from Staff I.

During interview on at 12:40 PM with Resident #3, he stated, he received assistance from Staff A, Staff B, Staff D, and Staff E. He reported, Staff H does not work in the facility anymore. He reported, Staff I is not a facility staff person.

During interview on at 1:45 p.m. with Resident #4, he stated that Staff I is Staff G's sister and she does not work here at the facility. He reported, Staff I sometimes visits the facility to spend time with Staff G, but she never provide services to any resident. He said, Staff H does not come to the facility anymore, for over a month.

During interview on at 12:02 PM with the administrator, she stated, the staff schedule can be change internally by the staff because they have been working in the facility for many years together. She reports, Staff H is an on-call staff, and Staff I was hired a month ago and works at night.

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Class III

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06

Based on observation, record review and interview, the facility failed to provide evidence of Level II background screenings for Staff B, D, and E.

The findings included:

Observation made during the course of the survey on at 9:00 AM revealed, Staff B, D, and E were interacting with facility residents and providing assistance with activities of daily living.

Review of the Staffing Pattern for 2014 showed that Staff B worked from 7:00 AM-6:00 PM with Saturday's off, Staff D worked from 7 AM-7 PM with Thursday's off, and Staff E worked from 7 AM-6 PM with Sunday's off.

Personnel records review documented it did not contain proof of a Level II background screening compliance for Staff B, D, and E.

During interview on at 12:10 PM with Resident #2, he stated, he received assistance from Staff B, D and E.

During interview on at 12:40 PM with Resident #3, he stated, he received assistance from Staff B, D, and E.

The background screening website was reviewed during the survey. Staff B and E results documented "A new screening is required." There was no background screening done for Staff D.

On at 12:02 PM, the administrator stated, Staff B, D and E had their background screenings done by Elder Affairs.

Unclassified Deficiency

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Oasis Home For The Elderly
33 West 26 Street
Hialeah, FL 33010

RE: CCR #2014009432

Dear Administrator:

This letter reports the findings of a Complaint Investigation survey that was conducted on , 2014 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe.

Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure
XG90

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone:(305) 593-3100: Fax:(305) 593-3121
AHCA.MyFlorida.com

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

[redacted], 2014

Oasis Home for the Elderly
33 West 26 Street
Hialeah, FL 33010
Attn: Carmen De La Mata

Dear [redacted] De La Mata:

This letter reports the findings of a complaint inspection survey (CCR# 2014009432) conducted from [redacted] by representatives of the Agency for Health Care Administration. Attached is the provider's copy of the State Form, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's request within **five (5) calendar days** of receipt of this report.

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

1) A0030 – Resident Care – Rights & Facility Procedures - Class I
The Assisted Living Facility failed to honor resident rights by providing adequate and appropriate health care and failed to follow emergency procedures and administer [redacted] ( ) to a resident. The non-compliance posed a direct threat to the resident and delayed necessary medical treatment. All current residents are at risk of harm or [redacted] until this deficient practice has been corrected.

Your facility must comply with the following:

1) Your facility must audit the records of each facility resident and compile an accurate list of residents with [redacted] ( ). Your facility must then designate locations for the list of [redacted] residents and the residents' [redacted] and implement a system for staff to identify whether a resident has a [redacted]. This information must be communicated to direct care staff and the information must be accessible during each shift. This must be completed **within 5 calendar days** from the date of this letter.

2) Your facility must have a written policy on steps to take in emergency situations, including sudden illness of a resident. Your facility is directed to review and revise any current policies regarding emergency procedures, [redacted] and resident [redacted] to ensure they are consistent and do not contradict each other. The emergency/ [redacted] policy must include:

- Directions for staff on the importance of initiating [redacted] unless a resident has a [redacted].
- Directions on calling emergency personnel.
- Directions on what staff in charge are to be notified and are responsible for follow-up.

- A plan for making all resident records (including medical records, medication records, resident emergency contacts and) available to direct care staff and emergency personnel.
- The location of the list of residents and the location of the hard copies of resident .
- This must be completed within **5 calendar days** from the date of this letter.

3) All facility employees must be retrained on the facility's emergency policy, ( ) and policy and procedures after the policies are written/revised. A roster of these employees and written verification of the training and training materials must be available for AHCA staff to review. This must be completed within **5 calendar days** from the date of this letter.

4) Your facility must review the staffing schedule and designate a staff person in charge who is the point of contact for direct care staff on each shift. This must be reflected on the staffing schedule. Your facility must also implement a way to communicate this information to staff so they know who the person in charge is during each shift.

5) Your facility must also ensure a staff person trained in First Aid and is on duty in the facility at all times. This information must be reflected on the staff schedule and communicated to all staff on duty in the facility. This must be completed within **5 calendar days** from the date of this letter

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 contact Verlande Exil, Health Facility Evaluator Supervisor, at (305) 593-3100.

Regards,

Arlene Mayo-Davis, RN
Field Office Manager

10/2/2014 - 6:02 PM

Ana du Fernandez -