STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968210	05/22/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
SPECIAL LOVING HOME, INC	652 NW 113TH TERRACE CORAL SPRINGS, FL 33071	

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

0000 - Initial Comments

An unannounced licensure complaint survey, CCR#2015002346, was conducted on through at Special Loving Home, Inc. The Assisted Living Facility had a deficiency identified at the time of the visit.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observations, interviews, and record review, the facility failed to ensure that a resident had a current Health Assessment (AHCA form 1823) that was reflective of the care and services needed in order to determine and maintain current residency, for 1 out of 3 residents' records reviewed (Resident #1).
The Findings Include:
Resident #1 was observed on at 9:45 AM, 10:20 AM, and 11:25 AM lying on his/her back with a cushion placed under his/her back. Resident #1 stated on at 9:45 AM that he/she had a on his/her bottom but it has healed.
Staff A, a Home Health Aide, stated on at 9:35 AM that there were no residents who had
The Manager and Owner of the facility stated on 10:10 AM that no resident residing at the facility has a The Manager stated Resident #1 did not have any upon admission. The Manager stated Resident #1 had an on his/her bottom from being The Manager stated Resident #1 came back from a hospital stay where Hospice inserted a
In an interview conducted on at 11:27 AM, Staff A stated he/she tries to get Resident #1 up but he/she does not want to all of the time. Staff A stated Resident #1 can turn himself/herself in bed. Staff A stated he/she empties the for the resident.
In an interview conducted on at 11:36 AM, Resident #1 ' s Hospice nurse stated he/she has a on the The nurse stated Resident #1 had a before that was heeled. The nurse added that the started opening on The Hospice nurse stated she/he told the facility staff to reposition Resident #1 every 2 hours. She stated the resident likes to stay on his/her back. She stated the facility told him/her that Resident #1 had a history of
Resident #1 ' s physician stated on at noon that he was not aware of a He stated that Resident #1 is bedridden. Staff A stated on at 12:12 PM that Resident #1 ' s Hospice nurse never told her to turn him/her every two hours.

On at 10:00 AM, Resident #1 ' s family member stated he/she was not aware of any The family member raised the question why the Manager wondered did not know about this. The family member stated Resident #1 had a in and has been bedridden since then.
A record review of Resident #1 ' s chart revealed an admission date of A Health Assessment (AHCA form 1823) dated documented diagnoses of muscle , Hypertrophy, and His/her physical or sensory limitations are noted as or behavioral status notes services are documented as Home Health. Resident #1 ' s current Activities of Daily Living (ADLs) are noted as supervision with eating and assistance with ambulation, bathing, dressing, self-care toileting, and transferring. The AHCA form 1823 indicates Resident #1 needs assistance with his/her walker. The 1823 notes Resident #1's needs can be met in an Assisted Living Facility (ALF) and that his is not

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bedridden.

A second AHCA form 1823 dated ..... noted diagnoses of , Chronic pain, Generalized (GAD), ... Chronic Kidney ..... and Right Below Knee Amputation (RBKA). Resident #1 ' s physical or sensory limitations are noted are unsteady gait secondary to RBKA. His/her or behavioral status is documented as Services are documented as medication management. The AHCA form 1823 documents the resident is independent with ambulation and eating. He/she requires assistance with bathing, dressing, self-care toileting, and transferring. The AHCA form 1823 notes Resident #1 ' s needs can be met in an ALF and that he is not bedridden. Review of Resident #1 ' s AHCA form 1823 reveal no documentation that he/she is on Hospice, has a , and a .

Review of Resident #1 ' s prescriptions revealed a ..... care consult ordered on ..... A prescription dated ..... ordered ..... care to his/her right heel. The instructions noted to cleanse the right heel with normal ..... (NS) and to apply granule spray to the area. The instructions noted to cover with Mepilex foam and secure with Kerlix gauze. A prescription dated ..... ordered a Hospice evaluation.

Further record review revealed a fax from a hospital Resident #1 was recently discharged from. The note, dated , documented a ..... left with the words ' resurfaced/healed. ' The ..... onset type is noted as community acquired. The Manager stated on at 10:10 AM that she contacted the Hospital requesting information on the ..... The Manager stated she was told by the hospital that the ..... was healed. She pointed to the word 'healed' on the document.

Resident #1 ' s progress notes revealed on ..... that his/her bottom was very red and round the area. The note documented a dressing in place on the right foot. A progress note dated ..... revealed Resident #1 did not get out of bed (oob) for awhile. He/she wanted to go back to bed. The note indicates a nurse came out for an evaluation. His/her bottom noted to be very red and around his area. The progress note revealed a physician's order for a ..... Further review of progress notes revealed on ..... that Resident #1 is in a wheelchair and needs assistance with almost all ADLs. The note documents Resident #1 is ..... On progress notes revealed Resident #1 came back to the facility from a rehabilitation center on ..... with Hospice care in place.

Review of Resident #1's Hospice Recertification Summary Report revealed a start of care date of ..... The summary indicates Resident #1 receives routine home care. The Hospice integrated Plan of Care (POC) dated ..... revealed a diagnosis of and adult . The POC did not list specific ..... care or repositioning instructions for Resident #1.

Hospice nursing facility orders reviewed revealed ..... care to left heel and ..... on ..... Hospice Visit Note Reports dated ..... note that Resident #1 spends most of the day in bed. The note documents he/she has

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a [illegible] on his/her left heel.

All three members of the facility staff including Staff A, the Manager, and Owner, were not aware Resident #1 had a [illegible] on his/her [illegible] despite [illegible] care notes in his/her chart and through an interview with the Hospice nurse. Resident #1's AHCA form 1823 did not indicate the resident had a [illegible], or that he/she was on Hospice The facility did not reassess the resident for continued residency to ensure they could meet the care needs of Resident #1 and that he/she met the criteria for continued residency.
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Special Loving Home, Inc
652 NW 113th Terrace
Coral Springs, FL 33071

RE: CCR #2015002346

Dear Administrator:

This letter reports the findings of a complaint survey completed on , 2015 through 22, 2015 bya representative of this office.

Attached is the provider's copy of the Statement of Deficiencies, State (5000-3547) Form, indicating no deficiencies were identified during this survey. **You will not receive a copy of this report in the mail; you will only receive this faxed copy.**

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 representative . Should you have any questions, please contact this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure: State (5000-3547) Form

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