STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953670	08/05/2016
NAME OF PROVIDER OR SUPPLIER **SOUTH DEERING RETIREMENT HOME,**	STREET ADDRESS, CITY, STATE, ZIP CODE **9730 SW 160 STREET** **MIAMI, FL 33157**	

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

0000 Initial Comments

A complaint (CCR#2016006716) survey was conducted from , 2016 through , 2016. South Deering Retirement Home, inc with limited mental health and limited nursing services components and license number 8674 had the following deficiencies identified at the time of the survey:

0010 Admissions - Continued Residency

Based on observation, record review, and interview, the Assisted Living Facility failed to discharge one (Resident #3) out of five sampled residents who no longer met the criteria for continued residency.

Findings included:

Observation on at 7:52 AM revealed, Caregiver A was the only caregiver in the facility taking care of Residents #3, #4, and #5.

In an interview on at 8:07 AM Caregiver A revealed, she was alone at the facility now taking care of the residents. Caregiver A stated, "Regularly we are just one employee for five residents because we cleaned it fast, we gave them medicines and breakfast early because they woke up early due to they go to bed early."

In an interview on at 8:11 AM Caregiver A stated, "I am a live in staff."
Review of the facility's record revealed, the staffing pattern posted on the bulletin board in the living for the month of 2016 and it included Caregiver A, Caregiver B, and Caregiver C.

Caregiver A did not have the Administrator's phone number. The listed Administrator was not available in person or by phone.

Observation on at 8:16 AM revealed, the , by Resident #3 did not have a bed and had a foul odor.

In an interview on at 8:03 AM Caregiver A revealed, Resident #3 had a mental health diagnoses, Resident #3 did not want to take medication, Resident #3 was assigned a private Resident #3 took clothes out, and disorganized everything. Sometimes Resident #3 did not want to take a shower.

In an interview on / at 8:18 AM Caregiver B revealed, Resident #3 took his mattress out to the yard and there was nothing they could do. Caregiver B stated, "He cleaned the yard and the

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neighborhood."

Observation on at 8:21 AM found Resident #3 standing outside looking through the kitchen window.

In an interview on at 8:21 AM Caregiver A reported, the facility received a call from a lady saying Resident #3 stood outside her property watching/looking, but Resident #3 was not aggressive.

Further observations on / at 8:39 AM, found Resident #3 standing outside looking through the dining and playing drum with the emergency water bottlers.

In an interview on / at 9:45 AM with Resident #3 revealed, the resident slept in the private Resident #3 reported, the mattress was put out of the be cleaned because it was soiled and Resident #3 wanted to do it by himself.

In an interview on at 9:48 AM Caregiver B revealed, the facility received a phone call related to Resident #3 looking into a neighbor's house. Caregiver B talked to the resident. In an interview on / at 9:50 AM Caregiver B revealed, Resident #3 did not want to go to the day program.

Review of the facility's admission and discharge log revealed, the facility identified Resident #3 as a Limited Mental Health resident. Resident #3's last health assessment (AHCA form 1823) was completed on and it revealed a diagnosis of . The health assessment also showed that Resident #3 needed total care for all activities of daily living (ambulation, dressing, eating, toileting, bathing, self-care and transferring) and Resident #3 needed assistance with self-administration of medications. There were progress notes completed in the record. On the following dates /, , / /, / /, /, / /, they reflected the resident's behaviors including reinforcing encouragement him for bathing, changing his clothes, and in general hygiene.

Resident #3's progress notes documented:
On revealed, Resident #3 has had a change in conduct, more quiet and eating less. Talked to the manager for making arrangements for psychiatrist appointment.
On revealed, Resident #3 has changed behavior, more quiet and .
On / revealed, Resident #3 did not want to go to the program. Resident #3 was not interacting and was very quiet.
On / revealed, Resident #3 did not want to go to the program. Resident #3 was more distracted, but so far behaviors in the ALF (Assisted Living Facility) were okay.
On , Resident #3 had problems at a business and was by police on /. Resident #3 was taken to the hospital in order to help stabilize his diagnosis. Resident #3 was discharged from

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the hospital on . On / Resident #3 went to the program in order to speak with the case manager and was and taken to a different hospital. Resident #3 returned to the ALF (Assisted Living Facility) on / . There was a progress note without a date that revealed, Resident #3 has not changed behaviors. Resident #3 was not taking medications, not going to the program. Resident #3 did not allow counseling and there wasn't good communication due to Resident #3's attitude. Resident #3 did not accept suggestions and was very selective with food.

In an interview on at 10:30 AM Caregiver B revealed, the Resident did not need total care for any of his activities of daily living.

Review of Resident #3's record revealed, the Community Living Support Llan and agreement was completed on . The limited mental health assessment was completed on , but it did not indicate if the resident was able to or not able to live in the community and an assisted living facility.

Review of Resident #3's Medication Observation Record (MOR) for the month of 2016 revealed, there was no record for medications. Review of Resident #3's MOR for the month of revealed, Resident #3 was hospitalized from / through / in the morning, and since / including the afternoon Resident #3 refused medications. The medications were 5 mg tablets (for mental) scheduled at 7:00 PM and 5 mg tab (for high) scheduled at 7:00 AM.

In an interview on at 11:07 AM Caregiver B revealed, the MOR was not done this month for Resident #3.

Medication reconciliation for Resident #3 revealed, there were two bottles and they were labeled:
- 5 mg tablets- take one tablet by mouth at bedtime with a dispense date of .
- 5 mg tab- take one tablet by mouth every day with a dispense date of / .

In an interview on at 11:11 AM Caregiver B reported, has not been ordered because Resident #3 has been refusing the medication and still has medication remaining. It was not reordered because the insurance did not want to pay for it, but it paid for the . In an interview on at 11:14 AM Caregiver B revealed, the primary doctor has not been informed that Resident #3 refused medications. In an interview on at 10:36 AM Caregiver B revealed, Resident #3's case manager has not brought the new community living support plan, agreement and limited mental health assessment.

In an interview on / at 10:58 AM Caregiver B stated, "Resident #3 did not want to eat regular

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food from the facility, just vegetables and I buy him fruits and vegetables. Resident #3 bathes himself daily, but he did not change clothes. I talked to him about the incident with the neighbor. I informed him that he could get in trouble and he answered that he would take the chance." Caregiver B revealed, there was no staff awake during the night shift."

Based on record reviews and interviews, the facility failed to properly assess Resident #3 for continued residency by not communicating with the resident's doctor after changes in the resident's behavior.

Class II

0026 Resident Care - Social & Leisure Activities

Based on record review and interview, the Assisted Living Facility failed to provide activities and to schedule activities at least six days a week.

Findings included:

Review of the facility's records revealed, the activity's calendar posted on the bulletin board in the living for the month of 2016 and it included activities such as puzzle, music, reading to residents, dominoes games, bingo games, arts & crafts, coloring, exercises, group conversations. Activities were scheduled from 2 PM to 4 PM.

In an interview on at 9:51 AM Caregiver B revealed, the main activity was to walk around the neighborhood, Caregiver B sometimes went with them but Resident #4 always goes by himself. They also sit outside on the patio, and went to the park. "We tried to do it weekly but sometimes they refused."

Class III

0030 Resident Care - Rights & Facility Procedures

Based on observation and interview, the Assisted Living Facility failed to honor resident's rights.

Findings included:

Observation on at 8:24 AM revealed, the facility's refrigerator had a chain with a closed padlock.

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In an interview on / at 9:27 AM Caregiver B revealed, the refrigerator was locked because there were certain residents who brought special food and other residents woke up in the middle of the night and ate all the food. Caregiver B revealed, this is the only refrigerator available at the facility. The key was usually in the drawer and the on duty caregiver was responsible for the key.

In an interview on at 9:30 AM the Caregiver B revealed, the family members brought in food for Thanksgiving and the next morning it was a disaster, a resident ate all of the food and left the residuals everywhere.

Class III

0081 Training - Staff In-Service

Based on record review and interview, the Assisted Living Facility failed to ensure that one (Caregiver C) of five sampled staff received in-service training.

Findings included:

Review of Caregiver C's personnel file revealed, Caregiver C's hire date was on /. Caregiver C did not have evidence in the personnel record of having completed inservices in Resident rights and Reporting adverse incidents & facility emergency procedures & preparedness including chain of command & staff roles relating to emergency evacuation.

In an interview on at 11:56 AM Caregiver B revealed, they thought major incidents covered everything.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based observation and interview, the Assisted Living Facility failed to provide a safe and clean living environment to facility residents.

Findings included:

Observation on at 8:13 AM revealed, there was a hallway near #1, #2, and #3, a common , a living the living not have a light.

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In an interview on . . . . / at 8:14 AM Caregiver B stated, " it broke yesterday."

Observation on at 8:16 AM revealed, next to the kitchen there was a door with a sign of private which connected with a ; this occupied by Resident #3. This not have a bed and had a foul odor.

Class III

L243 LMH - Training

Based on record review and interview, the Assisted Living Facility's caregivers failed to complete the limited mental health training required for an assisted living facility with limited mental health component in the license.

Findings included:

Review of Caregiver A's personnel file revealed that there was no evidence in the facility at the time of the survey of Caregiver A having completed a minimum of 3 hours of continuing education for limited mental health. Caregiver A last 3 hours continuing education for limited mental health were on .

Review of Caregiver C's personnel file revealed that there was no evidence in the facility at the time of the survey of Caregiver C having completed a minimum of 6 hours of limited mental health training within 6 months of employment in a limited mental health facility. Caregiver C's hire date was on / / .

In an interview on at 11:36 AM Caregiver A revealed that Caregiver A has not taken limited mental health training this year yet.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
South Deering Retirement Home,
9730 Sw 160 Street
Miami, FL 33157

Dear Administrator:

This letter reports the findings of a Complaint (#2016006716) inspection survey conducted on , 2016 and concluded on , 2016, by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, 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 ten days of receipt of this report.

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

St - A - 0010 - 429.26(1&9) Fs; 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= Class II

Directed Corrective Actions:

1. The facility must create a policy to address communication with health care providers and family members/ responsible parties following a change of condition. Examples include but not limited to: any condition which required medical attention or a transfer to an acute care facility. The policy should include that the Administrator be notified immediately of any resident change and documentation be made in the medical record of all notifications and any orders or instructions given to the staff. The Administrator must have an active role in determining level of care options for the resident. All direct care staff must be trained on the new policy. Documentation of the training, content and sign-in sheet, must be maintained in the facility and available for review by the Agency upon request. **This requirement must be met by , 2016.**

2. The facility must immediately refer any resident identified by any direct care staff member to have functional , physical/sensory limitations and /behavioral status inconsistent with their current health assessment or needing additional supplemental services and special precautions not identified in their current health assessment, to their physician/physician extender for an evaluation to determine a resident's current status, care needs and appropriateness to remain in the facility. **This requirement must be met by , 2016.**

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

3. The facility must develop and implement a policy and procedure for the coordination of care between third party providers and the facility. The policy must include who will be responsible for contacting and coordinating the third party providers, indicating how/when providers are notified of medical orders, specify notification instructions when the recommended care/ treatments are unable to be performed as ordered by the health care provider and how the facility will coordinate and provide oversight of the third party provider's care. The policy must address the facility's responsibility to document the coordination and oversight with the third party providers and the administrator's specific role in the coordination of care within the facility. As part of the policy, the heath care provider visit notes must be maintained in the resident record. The facility must implement a written log for all residents receiving care from any third party providers. The log must include, at a minimum, name of resident who is receiving care, the name of the third party provider who is providing the care, and documentation of any care services and treatments completed including the course of the progress of care/ services rendered to the resident. **This requirement must be met by , 2016.**

4. The facility must have medication observation records for all residents in the facility which include all medications (prescribed and over the counter products), including name, dose, route and schedule time. **This requirement must be met by , 2016.**

5. The facility must review every resident's health assessment, documented on an AHCA Form 1823, to ensure it is complete and accurately reflects the resident's condition and the examining physician/physician extender's assessment. The facility must apply the resident assessment/records requirements herein for any and all residents admitted to the facility. **This requirement must be met by , 2016.**

6. The facility must review every limited mental health resident's mental health assessment, community living support plan and agreements. **This requirement must be met by , 2016.**

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 Laura Manville, Survey and Certification Support Branch, at (727) 552-1955 Verlande Exil, Health Facility Evaluator Supervisor, Miami, (305) 593-3100

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve

D7JR

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[illegible], 2016

Administrator
South Beach Retirement Home,
9730 Sw 160 Street
Miami, FL 33157

RE: CCR #2016006716

Dear Administrator:

This letter reports the findings of a complaint licensure survey that was conducted on [illegible], 2016 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than [illegible], 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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

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