STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922174	01/23/2017
NAME OF PROVIDER OR SUPPLIER **LAURA'S ELDERLY HOMECARE, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **19500 SW 127TH AVENUE MIAMI, FL 33177**	

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

0000 - Initial Comments

A standard biennial survey was conducted on and concluded on . Laura's Elderly Home Care, Inc with limited mental health (LMH) component, license # 7992 had the following deficiencies identified at the time of survey:

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on record review and interview, the facility failed to ensure that the residents admitted to the facility met the admission criteria for one of six (#2) sampled residents.
Findings included:
Record review of Resident #2's health assessment dated had diagnoses mild persistent, caries, , female stress incontinence, major , , , disc, with or behavioral status , , inappropriate stress affect/ behaviors and with safety and elopement risk. Resident #2 needed supervision with bathing dressing, eating, self-care and toileting. In section D the individual needs cannot be met in an assisting living facility, needed 24 hours of , supervision.
On the facility sent a letter to the primary physician regarding Resident #2 that stated the following: this request is based on admission observation and discussion with resident, as the following items indicated on health assessment. The facility's letter summary showed that observation and discussion with Resident #2 and the resident's case manager as to health assessment indicated items, resident stated that assistance indicated is incorrect. She stated that she is not and needed no assistance or supervision with Activities of Daily Living (ADL). She also stated that the resident is not an elopement risk. The facility did not have any documentation that an elopement assess was done at the time of the admission.
During an interview on at 12:57 p.m. the administrator acknowledged that Resident #2 did not meet the admission criteria at the time of the admission.
Class III

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

Based on record review and interview, the facility failed to have as part of the continued residency criteria, a have a face-to-face medical examination by a health care provider at least every 3 years after the initial assessment for one of six (#4) sampled residents.
Finding included:
Record review showed that Resident #4's health assessment was dated with diagnoses of , , ( ), , , - , (PSVT).
During an interview on at 11:45 p.m. the Administrator stated that the resident's last assessment was on file. He acknowledged that health assessment on record was from 2012, He said,

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Administrator communicated over the phone with caseworker or legal guardian, providing the police report information.
Review of hospital records for Resident #1 revealed he was admitted in Orlando after being found by police. The records stated, on triage assessment , patient left group home, and not taking his meds, has history of , and . The patient was , . Admission diagnoses , , chronic. Mental status examination: the patient was brought in to the hospital on a by law enforcement. The patient reported missing, diagnosed with , and , and left his group home on the eighth. The patient was noncompliant with medications, present preoccupied. The appearance casual with no eye contact.
During a phone interview on at 10:53 a.m., the case manager from Resident #1's guardianship program stated, "I found out about 3 days ago when I went to the facility on to see my client \ that Resident #1 was missing from the facility since . I directed him to contact the local police office and file a missing person report."
During an interview on at 1:30 p.m., the Administrator stated, "We are here at the facility 24 hours, 7 days a week because we are living at the private area of the assisting living facility (ALF). We do bed checks every night making sure that all the residents are here, because we have two Residents #1 and #6 that are late night arrivals around 2:00 a.m. Their routine is that both of them are out until late night. Sometimes they come for dinner and go out again until the next day. They go out but we don't know where."
During an interview on at 2:08 p.m., Staff B (caregiver) stated, "I went to the gas station where he normally goes and the person told me that he was not been there. Staff B stated she overheard Resident #1 one day telling a person over the telephone that he will buy a ticket to go and visit his family. I do not know what family he has in Georgia. I did not ask any question to him, I did not document any of these incidents or his conduct on record or any paper. I thought that it was impossible for him without ID to buy the ticket, but see he did."
On at 2:08 p.m. the Administrator stated, "we did not do any search because he did not elope. We overheard him say that he wanted to go to his family member. I do not know what family he has in Georgia. We put two and two together and that's when we realized that he left to see his family, his cousin in Georgia; I don't know his cousin name." The Administrator stated that he did not call his mom to inform her of the incident. He stated, "I gave the mom's phone number to the police."
Class II

0125 - Fiscal - Surety Bonds - 429.27(2) FS; 58A-5.021(3) FAC

Based on interview, record review, and interview, the facility failed to have a updated surety bond with the minimum bond proceeds that equal twice the value of the residents' monthly aggregate income for three of six sampled residents (#2, #5, and #6).
Findings included:

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During an interview on at 12:40 p.m., the Administrator stated that he had two direct deposits for two residents (Residents #5 and #6). The Administrator further stated that he also received paper checks sent in the facility's name for Resident #2' .
During an interview on at 1:19 p.m., the Administrator stated that he requested the surety bound but he did not have it yet. He stated, "I'm going to review the mail to see if the paper arrived."
Facility record review showed the surety bond effective date 0 and expired for the sum of 5,000.00 dollars.
Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation, record review, and interview, the facility failed to provide a safe and decent living environment for facility residents.
Findings included:
Observation on at 9:28 a.m. found a roach was crawling on the staffing schedule posted in the kitchen in a glass frame. The Administrator cleaned up the insect with his hands. A pest control invoice or documentation was requested.
Review facility book found no documentation of pest control services. The Administrator did not provided pest control documentation.
During an interview on at 9:31 a.m. the Administrator acknowledged that house had roaches. He did not give any explanation.
Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview, the facility failed to file an adverse incident report for one of six sampled residents (#1) was missing from the facility and later found in Orlando, FL.
Findings included:
During the facility tour on at 8:47 a.m., the Administrator stated that Resident #1 occupied # , but he is not at the facility for six days, because he went to see a family member and did not returned to the facility.
Review of a fax received from a hospital for Resident #1 showed on the resident was and had been off his medications.
On at 10:11 a.m. the Administrator stated that he did not file an adverse incident with the Agency for Health Care Administration (AHCA), because he did not consider that Resident #1's absence was an elopement case because "he informed me that he was going to a family member in Georgia." The Administrator did not have any documentation, name or knowledge about a family member who lived in Georgia.
A review of the AHCA's Incident Report Database revealed there was no averse incident report

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"time is flying."
Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, interviews, and record review, the facility failed to have daily observation by designated staff or facility administrator of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident for one of six sampled residents (#1). Resident #1 was in Orlando, FL after a episode where he was missing from the facility, and hospitalized for six days for stabilization. The facility failed to contact the resident's health care provider and other appropriate party such as the resident's family, primary physician, legal guardian, health care surrogate, or case manager when the resident exhibited a significant change or was missing from the facility.
Findings included:
During the facility tour on at 8:47 a.m., the Administrator stated that Resident #1 occupied # , but that the resident had not been at the facility for six days, because he went to see a family member and did not return to the facility.
Record review of Resident #1 ' s file showed health assessment (AHCA form 1823) dated , had diagnoses of , effective , , type and resident need assistance with self-administration of medication. Medication observation record (MOR's) revealed a list of medications, , 1 mg (used to treat involuntary movements due to the side effects of certain , drugs), , 300 mg (used treat or to treat certain types of nerve pain), , 3 mg (used to treat certain mental/mood such as , , , , irritability associated with).). The facility had no documentation that the facility attempted to communicate with the resident's family, primary physician, legal guardian, or caseworker regarding the resident being missing from the facility. No information found in Resident #1's progress notes.
During an interview on at 10:11 a.m., the Administrator stated that Resident #1 did not return to the facility. He stated, "we had one case worker and legal guardian; we called the legal guardian after we realized on Monday morning that Resident #1 did not show up to sleep at the facility. We called the caseworker and they came on . The caseworker instructed me to call the police. We called the police and filed a report (dated)." The Administrator stated that he did not file an adverse incident with the Agency for Health Care Administration (AHCA), because he did not consider that Resident #1's absence was an elopement case because "he informed me that he was going to a family member in Georgia." The Administrator did not have any documentation, name or knowledge about a family member who lived in Georgia. The Administrator stated, "last night on at around 10:30 p.m. we received a called from the police that they found Resident #1 in another county. A Police officer informed me that they transferred Resident #1 to a nearby county hospital." At 10:50 A.M., the

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completed for Resident #1.
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Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on observation, interview, and record review, the facility failed to maintain an updated employee roster within the Agency for Health Care Administration's Clearinghouse.
Findings included:
Observation on at the time of arrival 8:45 a.m. Staff A (administrator) and Staff B (caregiver) were assisting residents with activities of daily living (ADLs)
A review of the Background Screening's Clearinghouse database showed that no employees were registered in the facility employee roster.
During an interview on at 2:37 p.m., the Administrator acknowledged that the employee roster had not been completed for the facility.
Unclassified