STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953662	**02/10/2017**
NAME OF PROVIDER OR SUPPLIER **FAIRWAY PARK RETIREMENT FACILITY CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **16324 S W 99TH COURT MIAMI, FL 33157**	

SUMMARY STATEMENT OF DEFICIENCIES
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Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on record review and interview, the facility failed to provide documentation of an eligible Level II background screening or an attestation of compliance with background screening for two of four sampled employees (Administrator, and Staff C).

Findings included:

Record review revealed, the Administrator started on and Staff C started on . A review of the Background Screening Clearinghouse database showed the Administrator and Staff C had an eligible Level I background screening. There was no documentation of the screening results, or an attestation of compliance with background screening, in the personnel records.

On at 3:30 PM, Ex-Employee D called the Administrator to confirm that all of the employees had their level II screenings in their files, but none were found on site.

Unclassified

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on observation and record review, the facility failed to maintain an accurate roster of its employees in the Background Screening Clearinghouse database.

Findings:

During inspections on , , ad between 8:30 am and 3:00 pm, observed the Administrator and Employee C at the facility providing meals, medication and other services to residents.

A review of the facility's roster in the Background Screening Clearinghouse database showed that no employees were listed as currently working there. The Administrator was not listed. Employee B was listed as discontinued in 2016. Employee C was listed as discontinued in , 2008. Employee D was listed as discontinued in , 2016.

Unclassified

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

Based on observation, interview and record review, the facility failed to ensure that persons providing

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care to residents, who had access to resident personal property and living areas, had an eligible Level II Background Screening (for Non-Staff E and F).

Findings included:

On at 7:05 am during a relicensure visit, five residents and two unidentified, non- staff persons were observed. Non Staff F was sleeping in # , in the resident #3. Non-Staff E was living in # , in the Resident #7. Staff C reported, she slept in the 'staff only' resident #7, who was hospitalized.

On at 9:35 am when asked if she provided care to residents, Non- Staff E stated, she only helped the residents if they needed it. At approximately 10:00 am, observed Non- Staff E in the facility kitchen cooking breakfast for the residents. At 12:30 pm, observed Non- Staff E prepare and serve lunch to Resident #5. Non-Staff E stated, she was a volunteer and during the days and evenings, she helped the female residents with bathing and adult brief changes. A review of the personnel records and of the Background Screening Clearinghouse Database showed for Non-Staff E, there was no personnel record, eligible level two background screening, or documentation of nutrition and safe food handling or any other training.

Interview on at 8:30 am, Resident #2 stated, Non-staff E did most of the cooking and cleaning in resident , and she fed the female residents if they needed help at mealtime.

On at 9:00 am, observed Staff C and Non-Staff E preparing breakfast for residents. Non-Staff E then served breakfast to Resident #4 in her .

On at approximately 12:00 noon, observed five residents and two Non- Staff persons in the facility. No staff was present. Non-Staff E stated, "Staff C stepped out for a moment. No staff is here. They've been gone for about a half hour. They went to get something for residents to eat."

Interview on at 12:05 pm, Resident #4, who was paralyzed and a right leg amputee, stated, "I don't get out of bed. Non Staff E changes my incontinence briefs. The owner and Non-Staff E give me baths and my medications. Non Staff E gives me food. My guardian comes by sometimes, but I don't remember their name." Non-Staff E was observed to pull back the bed covers on Resident #4 to show the resident's adult brief. Non Staff E stated, "It is dry. I change it for her."

On at 12:11 pm, Resident #6 was observed laying in bed in # . Resident #6 had a half full

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urinal on his nightstand, and no privacy screen was present. The resident stated that he shared the . . . Non-Staff F, and that he did use the urinal because he wore a leg brace and was unable to make it to the ˇ the night. He stated, Non-Staff F was present when he used the urinal. At 12:30 pm, non-Staff D stated, "I do everything. I help them dress and take a shower. I clean the house." Non-Staff F further stated, he helped his shower, and that he helped the other men in the facility.

On . . . at 12:20 pm, Non-Staff E stated, she had been mistaken, and Non-Staff F was in charge until the staff returned. Non-Staff F stated, he had been living and working at the facility for many years, and that he sometimes worked at a couple of other facilities.

On at 12:25 pm, the Administrator returned to the facility and stated, she had left to take Staff C to the doctor. She stated, Non-Staff F was trying to get his background screening and his training's back because he used to work at the facility long ago. She further stated, he now works at the facility overnight to help with medications and resident care.

On at 12:33 pm, Non-Staff F was asked what he did at the facility, and he stated, "I do everything. I help them dress and take a showers. I clean the house. I don't cook, but I would if I had to. He stated, "he helped his shower and that he helps the other men in the house."

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0000 - Initial Comments

A Standard Biennial Survey of Fairway Park Retirement Facility Corp (lic# 8673) was conducted on through . The following deficiencies were identified at the time of the survey:

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

Based on observation, interviews and record review, the facility failed to provide care and services appropriate to the needs of seven of seven residents (Residents #1-7). Resident #1 , after being hospitalized for a and a . This resident had been receiving medication administration by unqualified non-staff, who had been crushing the medication and putting it into food that the resident refused to eat. During a licensure inspection, six residents were found alone in the facility with no qualified staff present. Resident # 4, who was unable to get out of bed, was being provided medications, food and assistance with toileting by unqualified staff and non-staff.

Findings included:

1) A review of hospital records showed that Resident # 1 on , 2017 due to complications of a and a which occurred on , 2017. On admission to the hospital, the resident was diagnosed with by history, suspected , acute , , neutrophilic leucocytosis, hypertensive with an episode of accelerated , of chronic , severe protein-caloric , acute , major , and deep prophylaxis. A further review of the hospital's records showed that on , 2017, the resident's level was decreased, at 43 (below normal therapeutic range of 50-100 ug/mL). According to the US Food & Drug Administration, (also known by brand name) is a prescription medication used to treat and prevent . A review of hospice records showed that Resident #1's level on was 69.7 (within normal therapeutic range 50-100 ug/mL).

A review of Resident #1's record at the assisted living facility (ALF) showed the resident's health assessment dated stated that the resident needed medication administration by licensed staff, total care with ambulation and dressing, and assistance with bathing, eating, self care, toileting and transferring. The health assessment documented that the resident was bedridden. There were no progress notes, and no documentation that Resident #1 had experienced or been hospitalized, or that health care providers were contacted with concerns about the resident's well being. A review of the hospice records show that the residents hands and feet were contracted, and she was therefore unable to use her hands. A review of the ALF's Medication Observation Records (MOR) show that staff signed the MOR indicating that they assisted the resident with self-administration of medication. A

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review of the MORs showed that they were often signed by staff who were not on the facility's work schedule and who were not licensed to administer medications.

Interview on at 1:14 pm with the Administrator revealed regarding Resident #1's hospitalization on , 2017, "I was monitoring her . I called hospice and they came out on 1. The nurse came. I videoed the and showed it to the hospice nurse when she came, so that she could see it was less than 2 minutes. Resident #1 hadn't had any before that, since mid- when she had one less than 1 minute long. There were no other . She had no other problems in the month of . On , the paramedics saw the trembling and said it wasn't a , it was just trembling. They took her to the hospital."

Interview on at 3:45 pm with Resident #1's Daughter #1 revealed, her mother had a on and that her father saw it and called her. Daughter #1 called the Administrator, who she said she was busy, and who did not go to the facility until 1. Daughter #1 stated that she is a registered nurse, and that the administrator said she was a nurse. Daughter #1 further stated that Non-Staff #E was the predominant caregiver for her mother. She reported, Non-Staff #E used to put the pills into Resident #1's mouth via food. Daughter #1 stated, "They would crush the pills and Non Staff E would feed the pills to my mom. I saw the pills in my mom's food in . I knew it was the , because it was pink." She reported, she told the facility in or , not to crush the , because it is the pill and crushing it affects absorption. Daughter #1 stated, "Non-Staff E bathed and cleaned her mom, brushed her , and fed her. She stated, "Non-Staff E used to force feed my mom, and would give her water. I was worried about choking because my mom needed , precautions and I saw Non-Staff E put food or water into my mom's mouth and then walk away. I asked the hospice nurse for suction, but she said that suction was not allowed in ALFs. My mom's adult brief wasn't changed very often. Once when I visited I changed it myself and when I came back that evening, she was wearing the same one and it was soaking wet. The sheets had to be changed."
A review of a photograph and brief video clip sent by Daughter #1 showed Non-Staff E at Resident #1's bedside, appearing to provide care.

Interview on at approximately 9:45 am with Resident #1's Ex-husband revealed, he stated, "I visited her there every day. The place was not right. They gave Resident #1 no exercise. There were problems with food. Resident #1 couldn't feed herself. She used to smell. She wasn't getting changed. She wasn't receiving proper care. She just sat in the wheelchair all day, sitting in one position, with her head leaning to the left. Her legs weren't elevated. They didn't even put her in a recliner. They didn't puree the food or do anything to soften the food up. They would give her big chunks of regular meat." Resident #1's Ex-husband estimated that she lost about 80 lbs. while she was living there. He further

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stated, when he went to the facility on , he saw Resident #1 'jumping' and he told the Administrator, who said that this was happening because of the Resident #1 had the night before. Because of the 'jumping', Resident #1's Ex-husband asked the Administrator to call the rescue. She didn't want to call rescue, so Resident #1's Ex-husband called his daughter, and his daughter made the administrator call for help.

Interview on at 10:00 am with Resident #1's hospice nurse revealed, she was was caring for Resident #1 for about 3 months. She reported, "I saw Resident #1 at least every 14 days. She had a prognosis of 6 mos. or less to live. She had a diagnosis of in the / and another diagnosis. Had blinking of the eyes, marked decline while living there. Clamped her , and wouldn't eat. The daughter from Texas visited 2 or 3 times. The resident couldn't sit up anymore so they put her in a recliner. The daughter complained about her skin condition." The Nurse stated, she did not see a . A review of the hospice physician's progress note dated , 2016 showed Resident #1 had ongoing care for a . The hospice nurse further stated, the hospice aides who were providing Resident #1's baths called her about or eating problems. The nurse stated that she told the aides and the ALF staff not to force food, and to sit the resident upright. She stated, she was concerned about the resident getting out of bed because she didn't think the facility had enough staff to transfer Resident #1 either out of bed or back to bed, so they didn't take her out of bed. Resident #1 required 2 persons in order to transfer. After a few weeks there, Resident #1 was not able to sit in the wheelchair without falling forward. She thinks that a recliner was ordered for the resident. The hospice nurse stated, she was not called at all on New Year's eve or New Year's day by the facility because she was not on duty, and that she was not shown any video of the .

Interview on at 2:00 pm, Daughter #2 stated that she visited about every six weeks. During a visit she noticed that her mother had a large under her adult briefs. She found that her mother was soaking wet with . No hospice staff or other caregivers were assisting her mother. She stated, during her visits, she observed Non- Staff E acting like she was the caregiver for her mother. Non-Staff E was seen pushing a spoon into her mother's mouth. She further stated, she saw Non- Staff E crushing her mother's medications and putting them in applesauce and a pudding. When her mother did not eat all of her food with the medications in them, the food was thrown away. She stated, Non-Staff E told her that she always crushed her mothers medications in her food because this was the only way she could take them.

Interview on at 4:28 pm, Staff C stated, Resident #1 had many in . I used to help her with her meds. I sometimes put it in a spoon and put it in her mouth. We had to feed her because she couldn't feed herself. We had to feed her like a baby. We used to put the medication in her food."

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2) On at 7:05 am during a relicensure visit, five residents and two unidentified, non- staff persons were observed. Non Staff F was sleeping in # , in the resident #3. Non-Staff E was living in # , in the Resident #7. Staff C reported, she slept in the 'staff only' resident #7, who was hospitalized.

On at 9:35 am when asked if she provided care to residents, Non- Staff E stated, she only helped the residents if they needed it. At approximately 10:00 am, observed Non-Staff E in the facility kitchen cooking breakfast for the residents. At 12:30 pm, observed Non-Staff E prepare and serve lunch to Resident #5. Non-Staff E stated, she was a volunteer and during the days and evenings, she helped the female residents with bathing and adult brief changes. A review of the personnel records and of the Background Screening Clearinghouse Database showed for Non-Staff E, there was no personnel record, eligible level two background screening, or documentation of nutrition and safe food handling or any other training.

3) On at approximately 12:00 pm, five residents and two Non-Staff persons were observed in the facility. No staff were present. Non- Staff E stated, " Staff C stepped out for a moment. No staff is here. They've been gone for about a half hour. They went to get something for residents to eat."

Record review showed that Resident # 2, is , had no health assessment and his needs for care or assistance were unknown. Resident # 3, is , was diagnosed with / , accident, ( ), and . Resident #4, is , was diagnosed with , Gait Imbalance, , and Deformity. Resident # 5, is , was diagnosed with , Hypothyroidism, and . Resident # 6 had no file, and his needs for care or assistance were unknown. According to a hospital discharge record, the resident was diagnosed with , . Observation showed that the resident walked with difficulty, using a right leg brace and a cane. Resident #7 had no file, so his needs for care and assistance were unknown, however his mother (Non-Staff E) stated that he had a , that rendered him unable to care for himself.

Interview on at 12:05 pm, Resident #4, who was paralyzed and a right leg amputee, stated, "I don't get out of bed. Non Staff E changes my incontinence briefs. The owner and Non-Staff E give me baths and my medications. Non Staff E gives me food. My guardian comes by sometimes, but I don't remember their name." Non-Staff E was observed to pull back the bed covers on Resident #4 to show

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the resident's adult brief. Non Staff E stated, "It is dry. I change it for her."

On at 12:11 pm, Resident #6 was observed laying in bed in # . Resident #6 had a half full urinal on his nightstand, and no privacy screen was present. The resident stated that he shared the Non-Staff F, and that he did use the urinal because he wore a leg brace and was unable to make it to the the night. He stated, Non-Staff F was present when he used the urinal. At 12:30 pm, non-Staff D stated, "I do everything. I help them dress and take a shower. I clean the house." Non-Staff F further stated, he helped his shower, and that he helped the other men in the facility.

On at 12:20 pm, Non-Staff E stated, she had been mistaken, and that Non-Staff F was in charge until the staff returned. Non-Staff F stated, he had been living and working at the facility for many years, and that he sometimes worked at a couple of other facilities.

On at 12:25 pm, the Administrator returned to the facility stating, she had left to take Staff C to the doctor. She stated, Non-Staff F was trying to get his background screening and his training's back because he used to work at the facility long ago. She further stated, he now worked at the facility overnight to help with medications and resident care. At 12:35 pm, the Administrator changed her comments, and reported, Non-Staff F was a tenant, renting a her.

On at 12:33 pm, Non-Staff F was asked, what he did at the facility, and he stated, "I do everything. I help them dress and take a shower. I clean the house. I don't cook but, I would if I had to." He stated, he helped his shower and that he helps the other men in the house.

4) A review of Resident #4's MOR showed her medications were signed off as having been taken on , 8 and 9. A review of the medication card showed that the resident's medications were still in the medication card. On , 2017 at 9:40 am, staff C stated, the signatures on Resident #4's MOR were hers. She acknowledged, she had not given the residents medications on those days, and stated, "She wasn't sick so I didn't give them to her. When she's not sick we don't give her the medications. I know that 's wrong."

Class I

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the facility failed to keep centrally stored medications locked in a cabinet, a locked cart or other locked storage receptacle. The facility also failed to return or dispose of

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medications that were abandoned. The medications were stored unlocked in common areas where residents and visitors routinely spent time unsupervised by staff.

Findings included:

During inspections on , , ad between 8:30 am and 3:00 pm, observed residents 2, 3, 5, 6, and 7 walking around the facility, sitting in the living , and standing or eating in the kitchen, unsupervised by staff.

On at 9:30 AM, observed resident medications and syringes in unlocked kitchen drawers and cabinets:

-In the unlocked kitchen pantry with the food, observed a container of medications for Resident #6 in the cabinet, and in bags on the kitchen table: 10 mg, , 100 mg, , Eum 100 mg, , 1 mg, 20 mg, Aspir-low 81 mg, and Duoloxetine Dr 60 MGc.

-In the refrigerator side door top shelf observed an unlocked bag of Resident #7's medication: the medication was .

-In the unlocked top right kitchen cabinet, observed , Solution, a Stool Softener, CF, POT 100 mg. and Milk of Magnesia which belonged to a Resident #1,

-In the unlocked top left hand side cabinet found: Voltren Gel, of Cream 12% with no names on them.

-In the unlocked left hand kitchen drawer: Eighteen syringes with needles, eight boxes of Easy Comfort Lancets. Four more syringes were found in the right hand drawer.

-In the living , in an unlocked entertainment center: Sure Comfort Syringes 1/2 cc (0.5 ml) 50 units/ " 31 gauge, 100 single-use syringes, eight boxes, one box Inhalation Solution 1.25 mg, one box Inhale 3 ml and 90 , 2 mg for Resident #3.

Residents no longer living medications were at the facility to include: 6.25 mg, , 2 mg, 20 mg, 800 mg, and three bottles of , 325 mg.

Medication was found with the names scratched off the label included: , 800 mg.

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Medications for Resident (#4) was found in the small section of the unlocked entertainment center cabinet to include 20 mg, and Aspir-low 81 mg tab.

Medications found in the unlocked entertainment center for Resident #2 were: 120 / mg tab, 100 mg, and 5 mg. More medications were found for Resident #2 in pharmacy bags in an unlocked file cabinet to include, 10 mg, and 10 mg tab.

Employee C's medication was found on Resident #3's bed. The medication was 81 mg.

Record review showed Resident # 2, a , had no health assessment and his needs for care or assistance were unknown. Resident # 3, a , was diagnosed with / , accident, (, and . Resident #4, a , was diagnosed with , Gait Imbalance, and Deformity. Resident # 5, a , was diagnosed with , Hypothyroidism, . Resident # 6 had no file, and his needs for care or assistance were unknown. According to a hospital discharge record, the resident was diagnosed with , . Observation showed that the resident walked with difficulty, using a right leg brace and a cane. Resident #7 had no file, so his needs for care and assistance were unknown, however his mother (Non-Staff E) stated, he had a , that rendered him unable to care for himself. There was no documentation of the residents' to medications available for Residents #2, 6, and 7.

At approximately 10:00 am, Employee C stated, she would inform the Administrator that the medications were found unlocked.

Class II

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on observation, interview, and record review, the facility failed to ensure that it was under the supervision of a competent administrator, whose operation of it provided the management of all staff and the appropriate care of all residents as required by State Rule and Statute for Assisted Living Facilities. Residents #2-6 were found at the facility when no staff was present. The facility was operating with people who did not work there, and by inadequately trained staff. The untrained people were providing services for which they were not qualified, these services were given to seven of seven sampled

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residents (Residents #1-7). Resident #1 after receiving care, services and medication administration from non-staff people living at the facility. The facility had no documentation for several residents and staff. The facility had unsecured medications, including controlled medications and needles with syringes, were found in common areas. In addition, resident #4's medication observation record was found to be falsified because staff didn't administer the medications signed off as given to the resident.

Findings included:

1) On at approximately 12:00 pm, five residents and two Non-Staff persons were observed in the facility. No staff were present. Non- Staff E stated, " Staff C stepped out for a moment. No staff is here. They've been gone for about a half hour. They went to get something for residents to eat."

Record review showed that Resident # 2, is , had no health assessment and his needs for care or assistance were unknown. Resident # 3, is , was diagnosed with / , accident, ( ), , and . Resident #4, is , was diagnosed with , Gait Imbalance, and Deformity. Resident # 5, is , was diagnosed with , Hypothyroidism, and . Resident # 6 had no file, and his needs for care or assistance were unknown. According to a hospital discharge record, the resident was diagnosed with . Observation showed that the resident walked with difficulty, using a right leg brace and a cane. Resident #7 had no file, so his needs for care and assistance were unknown, however his mother (Non-Staff E) stated that he had a that rendered him unable to care for himself.

On at 12:20 pm, Non-Staff E stated, she had been mistaken, and that Non-Staff F was in charge until the staff returned. Non-Staff F stated, he had been living and working at the facility for many years, and that he sometimes worked at a couple of other facilities.

On at 12:25 pm, the Administrator returned to the facility stating, she had left to take Staff C to the doctor. She stated, Non-Staff F was trying to get his background screening and his training's back because he used to work at the facility long ago. She further stated, he now worked at the facility overnight to help with medications and resident care. At 12:35 pm, the Administrator changed her comments, and reported, Non-Staff F was a tenant, renting a her.

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On at 12:33 pm, Non-Staff F was asked, what he did at the facility, and he stated, "I do everything. I help them dress and take a shower. I clean the house. I don't cook but, I would if I had to." He stated, he helped his shower and that he helps the other men in the house.

2) On at 7:05 am during a relicensure visit, five residents and two unidentified, non- staff persons were observed. Non Staff F was sleeping in # , in the resident #3. Non-Staff E was living in # , in the Resident #7. Staff C reported, she slept in the 'staff only' resident #7, who was hospitalized.

On at 9:35 am when asked if she provided care to residents, Non- Staff E stated, she only helped the residents if they needed it. At approximately 10:00 am, observed Non- Staff E in the facility kitchen cooking breakfast for the residents. At 12:30 pm, observed Non- Staff E prepare and serve lunch to Resident #5. Non-Staff E stated, she was a volunteer and during the days and evenings, she helped the female residents with bathing and adult brief changes. A review of the personnel records and of the Background Screening Clearinghouse Database showed for Non-Staff E, there was no personnel record, eligible level two background screening, or documentation of nutrition and safe food handling or any other training.

Interview on at 8:30 am, Resident #2 stated, Non-staff E did most of the cooking and cleaning in resident , and she fed the female residents if they needed help at mealtime.

On at 9:00 am, observed Staff C and Non-Staff E preparing breakfast for residents. Non-Staff E then served breakfast to Resident #4 in her .

Interview on at 12:05 pm, Resident #4, who was paralyzed and a right leg amputee, stated, "I don't get out of bed. Non Staff E changes my incontinence briefs. The owner and Non-Staff E give me baths and my medications. Non Staff E gives me food. My guardian comes by sometimes, but I don't remember their name." Non-Staff E was observed to pull back the bed covers on Resident #4 to show the resident's adult brief. Non Staff E stated, "It is dry. I change it for her."

On at 12:11 pm, Resident #6 was observed laying in bed in # . Resident #6 had a half full urinal on his nightstand, and no privacy screen was present. The resident stated that he shared the Non-Staff F, and that he did use the urinal because he wore a leg brace and was unable to make it to the the night. He stated, Non-Staff F was present when he used the urinal. At 12:30 pm, non-Staff D stated, "I do everything. I help them dress and take a shower. I clean the house." Non-Staff F further stated, he helped his shower, and that he helped the other men in

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the facility.

3) A review of hospital records showed that Resident # 1 on , 2017 due to complications of a and a which occurred on , 2017. On admission to the hospital, the resident was diagnosed with by history, suspected , acute , , neutrophilic leucocytosis, hypertensive with an episode of accelerated , , of chronic , severe protein-caloric , acute , major , and deep prophylaxis. A further review of the hospital's records showed that on , 2017, the resident's , level was decreased, at 43 (below normal therapeutic range of 50-100 ug/mL). According to the US Food & Drug Administration, , (also known by brand name ,) is a prescription medication used to treat and prevent . A review of hospice records showed that Resident #1's , level on was 69.7 (within normal therapeutic range 50-100 ug/mL).

A review of Resident #1's record at the assisted living facility (ALF) showed the resident's health assessment dated stated that the resident needed medication administration by licensed staff, total care with ambulation and dressing, and assistance with bathing, eating, self care, toileting and transferring. The health assessment documented that the resident was bedridden. There were no progress notes, and no documentation that Resident #1 had experienced or been hospitalized, or that health care providers were contacted with concerns about the resident's well being. A review of the hospice records show that the residents hands and feet were contracted, and she was therefore unable to use her hands. A review of the ALF's Medication Observation Records (MOR) show that staff signed the MOR indicating that they assisted the resident with self-administration of medication. A review of the MORs showed that they were often signed by staff who were not on the facility's work schedule and who were not licensed and trained to administer medications.

4) On between 9:30 am and 2:00 pm, Resident #4 was observed watching TV. The Resident was bedridden. A review of Resident #4's record showed she was admitted on . A review of the Health Assessment (AHCA Form 1823) dated showed the type of services Resident #4 needed for Activities of Daily Living (ADL) including toileting and ambulating, were marked for Supervision. There was no documentation in the resident's file showing that the resident's condition had changed, or that these changes in her condition had been reported to her physician or to her guardian. Interview on at 2:30 pm, Staff C and the Administrator acknowledged, Resident #4 never left her bed or her .

A review of the resident records showed that no current weight was recorded for Residents #1-7.

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A review of the activities calendar showed that it was dated 2016. On , and between 8:00 am and 3:00 pm observed that no activities were conducted. Interview on at 1:00 pm, Resident # 2 stated, "No, we don't do that here. I usually go outside to smoke a cigarette and drink coffee, and after that I either watch television (TV) or go back to bed. Interview on at approximately 10:00 am, Resident #4 stated, she stays in bed all day and that's all she can do, plus watch TV all day or just sleep. She further stated, staff are usually in her TV with her.

Record review showed that there was no file for residents #6 and #7. A review of the closed file for Resident #1 showed that most documents in the file, including the resident contract, were blank or incomplete. There were no progress notes regarding multiple witnessed that the resident had experienced.

5) A review of the staff schedules showed that there was no schedule for 2017. A review of the staff schedules for 2016 and 2017 showed the Administrator, Staff B, Staff C and Staff D worked at the facility. A review of an email sent by the Administrator on showed Staff C was no longer a part of the staff since , 2016. On at approximately 1:30 pm, the Administrator stated, Staff D had resigned. She stated that she worked on weekends, and that Staff C worked Monday through Friday.

A review of the MORs showed that Staff B, who had resigned in 2016, signed off as having given medications to residents on Saturday, .

A review of the personnel records showed that there was no documentation of an medication training update for staff C. There was no documentation of updated Food Service training for any employee. There was no documentation of current negative test results for any employee or non-employee.

6) Observation on between 9:00 am and 2:00 pm revealed in # , a section of the ceiling over a residents bed had peeling paint. In # , the the toilet near the floor board had a section of peeling paint and plaster. On the sink counter top there were soiled adult briefs. On the rear patio observed the entire roof under boards had water damage and a black substance. On top of the same roof, observed a plastic tarp cover. On the front roof of the facility another tarp was found. On the rear patio observed old mattresses and other debris. Inside of the facility front , the ceiling fan was covered with a thick layer of dust on every blade. The air vent on the ceiling in the front covered by a black substance.

7) On at approximately 10:00 am, observed the following, unlocked in kitchen cabinets and

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drawers, file cabinets and unlocked china cabinets in the common living (photos):
-Approximately 20 loose syringes with needles,
-Over the counter medications- , gum, , , syrup, milk of magnesia, and stool softener,
-Prescription medications for resident #6: 10 mg, , 100 mg, and , Eum 100 mg, , 1 mg, 10 mg, 20 mg, Aspir-low 81 mg, and Duoloxetine Dr 60 MGc.
-Prescription medications for residents who no longer lived at the facility - 325 mg, 20 mg, 6.25 mg, Renevela, 800 mg, POT 108 mg, , 800 mg, 100 mg, , 10 mg,
-Approximately 8 boxes of 100 count syringes for residents who no longer live at the facility photos were obtained.

8) A review of Resident #4's MOR showed that her medications were signed off as having been taken on , 8 and 9. A review of the medication card showed that the resident's medications were still in the medication card. On , 2017 at 9:40 am, staff C stated, the signatures on Resident #4's MOR were hers. She acknowledged, she had not given the resident's medications on those days and stated, "She wasn't sick so I didn't give them to her. When she's not sick we don't give her the medications. I know that 's wrong."

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0000 - Initial Comments

A Standard Biennial Survey of Fairway Park Retirement Facility Corp (lic# 8673) was conducted on through . The following deficiencies were identified at the time of the survey:

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

Based on observation, interviews and record review, the facility failed to provide care and services appropriate to the needs of seven of seven residents (Residents #1-7). Resident #1 , after being hospitalized for a and a . This resident had been receiving medication administration by unqualified non-staff, who had been crushing the medication and putting it into food that the resident refused to eat. During a licensure inspection, six residents were found alone in the facility with no qualified staff present. Resident # 4, who was unable to get out of bed, was being provided medications, food and assistance with toileting by unqualified staff and non-staff.

Findings included:

1) A review of hospital records showed that Resident # 1 on , 2017 due to complications of a and a which occurred on , 2017. On admission to the hospital, the resident was diagnosed with by history, suspected , acute , , neutrophilic leucocytosis, hypertensive with an episode of accelerated , , of chronic , severe protein-caloric , acute , , major , and deep prophylaxis. A further review of the hospital's records showed that on , 2017, the resident's , level was decreased, at 43 (below normal therapeutic range of 50-100 ug/mL). According to the US Food & Drug Administration, , (also known by brand name ,) is a prescription medication used to treat and prevent . A review of hospice records showed that Resident #1's , level on was 69.7 (within normal therapeutic range 50-100 ug/mL).

A review of Resident #1's record at the assisted living facility (ALF) showed the resident's health assessment dated stated that the resident needed medication administration by licensed staff, total care with ambulation and dressing, and assistance with bathing, eating, self care, toileting and transferring. The health assessment documented that the resident was bedridden. There were no progress notes, and no documentation that Resident #1 had experienced or been hospitalized, or that health care providers were contacted with concerns about the resident's well being. A review of the hospice records show that the residents hands and feet were contracted, and she was therefore unable to use her hands. A review of the ALF's Medication Observation Records (MOR) show that staff signed the MOR indicating that they assisted the resident with self-administration of medication. A

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review of the MORs showed that they were often signed by staff who were not on the facility's work schedule and who were not licensed to administer medications.

Interview on at 1:14 pm with the Administrator revealed regarding Resident #1's hospitalization on , 2017, "I was monitoring her . I called hospice and they came out on 1. The nurse came. I videoed the and showed it to the hospice nurse when she came, so that she could see it was less than 2 minutes. Resident #1 hadn't had any before that, since mid- when she had one less than 1 minute long. There were no other . She had no other problems in the month of . On , the paramedics saw the trembling and said it wasn't a , it was just trembling. They took her to the hospital."

Interview on at 3:45 pm with Resident #1's Daughter #1 revealed, her mother had a on and that her father saw it and called her. Daughter #1 called the Administrator, who she said she was busy, and who did not go to the facility until 1. Daughter #1 stated that she is a registered nurse, and that the administrator said she was a nurse. Daughter #1 further stated that Non-Staff #E was the predominant caregiver for her mother. She reported, Non-Staff #E used to put the pills into Resident #1's mouth via food. Daughter #1 stated, "They would crush the pills and Non Staff E would feed the pills to my mom. I saw the pills in my mom's food in . I knew it was the , because it was pink." She reported, she told the facility in or , not to crush the , because it is the pill and crushing it affects absorption. Daughter #1 stated, "Non-Staff E bathed and cleaned her mom, brushed her , and fed her. She stated, "Non-Staff E used to force feed my mom, and would give her water. I was worried about choking because my mom needed , precautions and I saw Non-Staff E put food or water into my mom's mouth and then walk away. I asked the hospice nurse for suction, but she said that suction was not allowed in ALFs. My mom's adult brief wasn't changed very often. Once when I visited I changed it myself and when I came back that evening, she was wearing the same one and it was soaking wet. The sheets had to be changed."
A review of a photograph and brief video clip sent by Daughter #1 showed Non-Staff E at Resident #1's bedside, appearing to provide care.

Interview on at approximately 9:45 am with Resident #1's Ex-husband revealed, he stated, "I visited her there every day. The place was not right. They gave Resident #1 no exercise. There were problems with food. Resident #1 couldn't feed herself. She used to smell. She wasn't getting changed. She wasn't receiving proper care. She just sat in the wheelchair all day, sitting in one position, with her head leaning to the left. Her legs weren't elevated. They didn't even put her in a recliner. They didn't puree the food or do anything to soften the food up. They would give her big chunks of regular meat." Resident #1's Ex-husband estimated that she lost about 80 lbs. while she was living there. He further

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stated, when he went to the facility on , he saw Resident #1 'jumping' and he told the Administrator, who said that this was happening because of the Resident #1 had the night before. Because of the 'jumping', Resident #1's Ex-husband asked the Administrator to call the rescue. She didn't want to call rescue, so Resident #1's Ex-husband called his daughter, and his daughter made the administrator call for help.

Interview on at 10:00 am with Resident #1's hospice nurse revealed, she was was caring for Resident #1 for about 3 months. She reported, "I saw Resident #1 at least every 14 days. She had a prognosis of 6 mos. or less to live. She had a diagnosis of in the / and another diagnosis. Had blinking of the eyes, marked decline while living there. Clamped her , and wouldn't eat. The daughter from Texas visited 2 or 3 times. The resident couldn't sit up anymore so they put her in a recliner. The daughter complained about her skin condition." The Nurse stated, she did not see a . A review of the hospice physician's progress note dated , 2016 showed Resident #1 had ongoing care for a . The hospice nurse further stated, the hospice aides who were providing Resident #1's baths called her about or eating problems. The nurse stated that she told the aides and the ALF staff not to force food, and to sit the resident upright. She stated, she was concerned about the resident getting out of bed because she didn't think the facility had enough staff to transfer Resident #1 either out of bed or back to bed, so they didn't take her out of bed. Resident #1 required 2 persons in order to transfer. After a few weeks there, Resident #1 was not able to sit in the wheelchair without falling forward. She thinks that a recliner was ordered for the resident. The hospice nurse stated, she was not called at all on New Year's eve or New Year's day by the facility because she was not on duty, and that she was not shown any video of the .

Interview on at 2:00 pm, Daughter #2 stated that she visited about every six weeks. During a visit she noticed that her mother had a large under her adult briefs. She found that her mother was soaking wet with . No hospice staff or other caregivers were assisting her mother. She stated, during her visits, she observed Non- Staff E acting like she was the caregiver for her mother. Non-Staff E was seen pushing a spoon into her mother's mouth. She further stated, she saw Non- Staff E crushing her mother's medications and putting them in applesauce and a pudding. When her mother did not eat all of her food with the medications in them, the food was thrown away. She stated, Non-Staff E told her that she always crushed her mothers medications in her food because this was the only way she could take them.

Interview on at 4:28 pm, Staff C stated, Resident #1 had many in . I used to help her with her meds. I sometimes put it in a spoon and put it in her mouth. We had to feed her because she couldn't feed herself. We had to feed her like a baby. We used to put the medication in her food."

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2) On at 7:05 am during a relicensure visit, five residents and two unidentified, non- staff persons were observed. Non Staff F was sleeping in # , in the resident #3. Non-Staff E was living in # , in the Resident #7. Staff C reported, she slept in the 'staff only' resident #7, who was hospitalized.

On at 9:35 am when asked if she provided care to residents, Non- Staff E stated, she only helped the residents if they needed it. At approximately 10:00 am, observed Non-Staff E in the facility kitchen cooking breakfast for the residents. At 12:30 pm, observed Non-Staff E prepare and serve lunch to Resident #5. Non-Staff E stated, she was a volunteer and during the days and evenings, she helped the female residents with bathing and adult brief changes. A review of the personnel records and of the Background Screening Clearinghouse Database showed for Non-Staff E, there was no personnel record, eligible level two background screening, or documentation of nutrition and safe food handling or any other training.

3) On at approximately 12:00 pm, five residents and two Non-Staff persons were observed in the facility. No staff were present. Non- Staff E stated, " Staff C stepped out for a moment. No staff is here. They've been gone for about a half hour. They went to get something for residents to eat."

Record review showed that Resident # 2, is , had no health assessment and his needs for care or assistance were unknown. Resident # 3, is , was diagnosed with / , accident, ( ), and . Resident #4, is , was diagnosed with , Gait Imbalance, , and Deformity. Resident # 5, is , was diagnosed with , Hypothyroidism, and . Resident # 6 had no file, and his needs for care or assistance were unknown. According to a hospital discharge record, the resident was diagnosed with , . Observation showed that the resident walked with difficulty, using a right leg brace and a cane. Resident #7 had no file, so his needs for care and assistance were unknown, however his mother (Non-Staff E) stated that he had a , that rendered him unable to care for himself.

Interview on at 12:05 pm, Resident #4, who was paralyzed and a right leg amputee, stated, "I don't get out of bed. Non Staff E changes my incontinence briefs. The owner and Non-Staff E give me baths and my medications. Non Staff E gives me food. My guardian comes by sometimes, but I don't remember their name." Non-Staff E was observed to pull back the bed covers on Resident #4 to show

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the resident's adult brief. Non Staff E stated, "It is dry. I change it for her."

On at 12:11 pm, Resident #6 was observed laying in bed in # . Resident #6 had a half full urinal on his nightstand, and no privacy screen was present. The resident stated that he shared the Non-Staff F, and that he did use the urinal because he wore a leg brace and was unable to make it to the the night. He stated, Non-Staff F was present when he used the urinal. At 12:30 pm, non-Staff D stated, "I do everything. I help them dress and take a shower. I clean the house." Non-Staff F further stated, he helped his shower, and that he helped the other men in the facility.

On at 12:20 pm, Non-Staff E stated, she had been mistaken, and that Non-Staff F was in charge until the staff returned. Non-Staff F stated, he had been living and working at the facility for many years, and that he sometimes worked at a couple of other facilities.

On at 12:25 pm, the Administrator returned to the facility stating, she had left to take Staff C to the doctor. She stated, Non-Staff F was trying to get his background screening and his training's back because he used to work at the facility long ago. She further stated, he now worked at the facility overnight to help with medications and resident care. At 12:35 pm, the Administrator changed her comments, and reported, Non-Staff F was a tenant, renting a her.

On at 12:33 pm, Non-Staff F was asked, what he did at the facility, and he stated, "I do everything. I help them dress and take a shower. I clean the house. I don't cook but, I would if I had to." He stated, he helped his shower and that he helps the other men in the house.

4) A review of Resident #4's MOR showed her medications were signed off as having been taken on , 8 and 9. A review of the medication card showed that the resident's medications were still in the medication card. On , 2017 at 9:40 am, staff C stated, the signatures on Resident #4's MOR were hers. She acknowledged, she had not given the residents medications on those days, and stated, "She wasn't sick so I didn't give them to her. When she's not sick we don't give her the medications. I know that 's wrong."

Class I

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the facility failed to keep centrally stored medications locked in a cabinet, a locked cart or other locked storage receptacle. The facility also failed to return or dispose of

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medications that were abandoned. The medications were stored unlocked in common areas where residents and visitors routinely spent time unsupervised by staff.

Findings included:

During inspections on , , ad between 8:30 am and 3:00 pm, observed residents 2, 3, 5, 6, and 7 walking around the facility, sitting in the living , and standing or eating in the kitchen, unsupervised by staff.

On at 9:30 AM, observed resident medications and syringes in unlocked kitchen drawers and cabinets:

-In the unlocked kitchen pantry with the food, observed a container of medications for Resident #6 in the cabinet, and in bags on the kitchen table: 10 mg, , 100 mg, , Eum 100 mg, , 1 mg, 20 mg, Aspir-low 81 mg, and Duoloxetine Dr 60 MGc.

-In the refrigerator side door top shelf observed an unlocked bag of Resident #7's medication: the medication was .

-In the unlocked top right kitchen cabinet, observed , Solution, a Stool Softener, CF, POT 100 mg. and Milk of Magnesia which belonged to a Resident #1,

-In the unlocked top left hand side cabinet found: Voltren Gel, of Cream 12% with no names on them.

-In the unlocked left hand kitchen drawer: Eighteen syringes with needles, eight boxes of Easy Comfort Lancets. Four more syringes were found in the right hand drawer.

-In the living , in an unlocked entertainment center: Sure Comfort Syringes 1/2 cc (0.5 ml) 50 units/ " 31 gauge, 100 single-use syringes, eight boxes, one box Inhalation Solution 1.25 mg, one box Inhale 3 ml and 90 , 2 mg for Resident #3.

Residents no longer living medications were at the facility to include: 6.25 mg, , 2 mg, 20 mg, 800 mg, and three bottles of , 325 mg.

Medication was found with the names scratched off the label included: , 800 mg.

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Medications for Resident (#4) was found in the small section of the unlocked entertainment center cabinet to include 20 mg, and Aspir-low 81 mg tab.

Medications found in the unlocked entertainment center for Resident #2 were: 120 / mg tab, 100 mg, and 5 mg. More medications were found for Resident #2 in pharmacy bags in an unlocked file cabinet to include, 10 mg, and 10 mg tab.

Employee C's medication was found on Resident #3's bed. The medication was 81 mg.

Record review showed Resident # 2, a , had no health assessment and his needs for care or assistance were unknown. Resident # 3, a , was diagnosed with / , accident, (, and . Resident #4, a , was diagnosed with , Gait Imbalance, and Deformity. Resident # 5, a , was diagnosed with , Hypothoyroidism, . Resident # 6 had no file, and his needs for care or assistance were unknown. According to a hospital discharge record, the resident was diagnosed with . Observation showed that the resident walked with difficulty, using a right leg brace and a cane. Resident #7 had no file, so his needs for care and assistance were unknown, however his mother (Non-Staff E) stated, he had a that rendered him unable to care for himself. There was no documentation of the residents' to medications available for Residents #2, 6, and 7.

At approximately 10:00 am, Employee C stated, she would inform the Administrator that the medications were found unlocked.

Class II

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on observation, interview, and record review, the facility failed to ensure that it was under the supervision of a competent administrator, whose operation of it provided the management of all staff and the appropriate care of all residents as required by State Rule and Statute for Assisted Living Facilities. Residents #2-6 were found at the facility when no staff was present. The facility was operating with people who did not work there, and by inadequately trained staff. The untrained people were providing services for which they were not qualified, these services were given to seven of seven sampled

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residents (Residents #1-7). Resident #1 after receiving care, services and medication administration from non-staff people living at the facility. The facility had no documentation for several residents and staff. The facility had unsecured medications, including controlled medications and needles with syringes, were found in common areas. In addition, resident #4's medication observation record was found to be falsified because staff didn't administer the medications signed off as given to the resident.

Findings included:

1) On at approximately 12:00 pm, five residents and two Non-Staff persons were observed in the facility. No staff were present. Non- Staff E stated, " Staff C stepped out for a moment. No staff is here. They've been gone for about a half hour. They went to get something for residents to eat."

Record review showed that Resident # 2, is , had no health assessment and his needs for care or assistance were unknown. Resident # 3, is , was diagnosed with / , accident, ( ), , and . Resident #4, is , was diagnosed with , Gait Imbalance, and Deformity. Resident # 5, is , was diagnosed with , Hypothyroidism, and . Resident # 6 had no file, and his needs for care or assistance were unknown. According to a hospital discharge record, the resident was diagnosed with . Observation showed that the resident walked with difficulty, using a right leg brace and a cane. Resident #7 had no file, so his needs for care and assistance were unknown, however his mother (Non-Staff E) stated that he had a that rendered him unable to care for himself.

On at 12:20 pm, Non-Staff E stated, she had been mistaken, and that Non-Staff F was in charge until the staff returned. Non-Staff F stated, he had been living and working at the facility for many years, and that he sometimes worked at a couple of other facilities.

On at 12:25 pm, the Administrator returned to the facility stating, she had left to take Staff C to the doctor. She stated, Non-Staff F was trying to get his background screening and his training's back because he used to work at the facility long ago. She further stated, he now worked at the facility overnight to help with medications and resident care. At 12:35 pm, the Administrator changed her comments, and reported, Non-Staff F was a tenant, renting a her.

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FAIRWAY PARK RETIREMENT FACILITY CORP	16324 S W 99TH COURT MIAMI, FL 33157

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

On at 12:33 pm, Non-Staff F was asked, what he did at the facility, and he stated, "I do everything. I help them dress and take a shower. I clean the house. I don't cook but, I would if I had to." He stated, he helped his shower and that he helps the other men in the house.

2) On at 7:05 am during a relicensure visit, five residents and two unidentified, non- staff persons were observed. Non Staff F was sleeping in # , in the resident #3. Non-Staff E was living in # , in the Resident #7. Staff C reported, she slept in the 'staff only' resident #7, who was hospitalized.

On at 9:35 am when asked if she provided care to residents, Non- Staff E stated, she only helped the residents if they needed it. At approximately 10:00 am, observed Non- Staff E in the facility kitchen cooking breakfast for the residents. At 12:30 pm, observed Non- Staff E prepare and serve lunch to Resident #5. Non-Staff E stated, she was a volunteer and during the days and evenings, she helped the female residents with bathing and adult brief changes. A review of the personnel records and of the Background Screening Clearinghouse Database showed for Non-Staff E, there was no personnel record, eligible level two background screening, or documentation of nutrition and safe food handling or any other training.

Interview on at 8:30 am, Resident #2 stated, Non-staff E did most of the cooking and cleaning in resident , and she fed the female residents if they needed help at mealtime.

On at 9:00 am, observed Staff C and Non-Staff E preparing breakfast for residents. Non-Staff E then served breakfast to Resident #4 in her .

Interview on at 12:05 pm, Resident #4, who was paralyzed and a right leg amputee, stated, "I don't get out of bed. Non Staff E changes my incontinence briefs. The owner and Non-Staff E give me baths and my medications. Non Staff E gives me food. My guardian comes by sometimes, but I don't remember their name." Non-Staff E was observed to pull back the bed covers on Resident #4 to show the resident's adult brief. Non Staff E stated, "It is dry. I change it for her."

On at 12:11 pm, Resident #6 was observed laying in bed in # . Resident #6 had a half full urinal on his nightstand, and no privacy screen was present. The resident stated that he shared the Non-Staff F, and that he did use the urinal because he wore a leg brace and was unable to make it to the the night. He stated, Non-Staff F was present when he used the urinal. At 12:30 pm, non-Staff D stated, "I do everything. I help them dress and take a shower. I clean the house." Non-Staff F further stated, he helped his shower, and that he helped the other men in

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the facility.

3) A review of hospital records showed that Resident # 1 on , 2017 due to complications of a and a which occurred on , 2017. On admission to the hospital, the resident was diagnosed with by history, suspected , acute , , neutrophilic leucocytosis, hypertensive with an episode of accelerated , of chronic , severe protein-caloric , acute , major , and deep prophylaxis. A further review of the hospital's records showed that on , 2017, the resident's level was decreased, at 43 (below normal therapeutic range of 50-100 ug/mL). According to the US Food & Drug Administration, (also known by brand name) is a prescription medication used to treat and prevent . A review of hospice records showed that Resident #1's level on was 69.7 (within normal therapeutic range 50-100 ug/mL).

A review of Resident #1's record at the assisted living facility (ALF) showed the resident's health assessment dated stated that the resident needed medication administration by licensed staff, total care with ambulation and dressing, and assistance with bathing, eating, self care, toileting and transferring. The health assessment documented that the resident was bedridden. There were no progress notes, and no documentation that Resident #1 had experienced or been hospitalized, or that health care providers were contacted with concerns about the resident's well being. A review of the hospice records show that the residents hands and feet were contracted, and she was therefore unable to use her hands. A review of the ALF's Medication Observation Records (MOR) show that staff signed the MOR indicating that they assisted the resident with self-administration of medication. A review of the MORs showed that they were often signed by staff who were not on the facility's work schedule and who were not licensed and trained to administer medications.

4) On between 9:30 am and 2:00 pm, Resident #4 was observed watching TV. The Resident was bedridden. A review of Resident #4's record showed she was admitted on . A review of the Health Assessment (AHCA Form 1823) dated showed the type of services Resident #4 needed for Activities of Daily Living (ADL) including toileting and ambulating, were marked for Supervision. There was no documentation in the resident's file showing that the resident's condition had changed, or that these changes in her condition had been reported to her physician or to her guardian. Interview on at 2:30 pm, Staff C and the Administrator acknowledged, Resident #4 never left her bed or her .

A review of the resident records showed that no current weight was recorded for Residents #1-7.

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A review of the activities calendar showed that it was dated 2016. On , and between 8:00 am and 3:00 pm observed that no activities were conducted. Interview on at 1:00 pm, Resident # 2 stated, "No, we don't do that here. I usually go outside to smoke a cigarette and drink coffee, and after that I either watch television (TV) or go back to bed. Interview on at approximately 10:00 am, Resident #4 stated, she stays in bed all day and that's all she can do, plus watch TV all day or just sleep. She further stated, staff are usually in her TV with her.

Record review showed that there was no file for residents #6 and #7. A review of the closed file for Resident #1 showed that most documents in the file, including the resident contract, were blank or incomplete. There were no progress notes regarding multiple witnessed that the resident had experienced.

5) A review of the staff schedules showed that there was no schedule for 2017. A review of the staff schedules for 2016 and 2017 showed the Administrator, Staff B, Staff C and Staff D worked at the facility. A review of an email sent by the Administrator on showed Staff C was no longer a part of the staff since , 2016. On at approximately 1:30 pm, the Administrator stated, Staff D had resigned. She stated that she worked on weekends, and that Staff C worked Monday through Friday.

A review of the MORs showed that Staff B, who had resigned in 2016, signed off as having given medications to residents on Saturday, .

A review of the personnel records showed that there was no documentation of an medication training update for staff C. There was no documentation of updated Food Service training for any employee. There was no documentation of current negative test results for any employee or non-employee.

6) Observation on between 9:00 am and 2:00 pm revealed in # , a section of the ceiling over a residents bed had peeling paint. In # , the the toilet near the floor board had a section of peeling paint and plaster. On the sink counter top there were soiled adult briefs. On the rear patio observed the entire roof under boards had water damage and a black substance. On top of the same roof, observed a plastic tarp cover. On the front roof of the facility another tarp was found. On the rear patio observed old mattresses and other debris. Inside of the facility front , the ceiling fan was covered with a thick layer of dust on every blade. The air vent on the ceiling in the front covered by a black substance.

7) On at approximately 10:00 am, observed the following, unlocked in kitchen cabinets and

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drawers, file cabinets and unlocked china cabinets in the common living (photos):
-Approximately 20 loose syringes with needles,
-Over the counter medications- , gum, , , syrup, milk of magnesia, and stool softener,
-Prescription medications for resident #6: 10 mg, , 100 mg, and , Eum 100 mg, , 1 mg, 10 mg, 20 mg, Aspir-low 81 mg, and Duoloxetine Dr 60 MGc.
-Prescription medications for residents who no longer lived at the facility - 325 mg, 20 mg, 6.25 mg, Renevela, 800 mg, POT 108 mg, , 800 mg, 100 mg, , 10 mg,
-Approximately 8 boxes of 100 count syringes for residents who no longer live at the facility photos were obtained.

8) A review of Resident #4's MOR showed that her medications were signed off as having been taken on , 8 and 9. A review of the medication card showed that the resident's medications were still in the medication card. On , 2017 at 9:40 am, staff C stated, the signatures on Resident #4's MOR were hers. She acknowledged, she had not given the resident's medications on those days and stated, "She wasn't sick so I didn't give them to her. When she's not sick we don't give her the medications. I know that 's wrong."

Class I

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Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on record review and interview, the facility failed to provide documentation of an eligible Level II background screening or an attestation of compliance with background screening for two of four sampled employees (Administrator, and Staff C).

Findings included:

Record review revealed, the Administrator started on and Staff C started on . A review of the Background Screening Clearinghouse database showed the Administrator and Staff C had an eligible Level I background screening. There was no documentation of the screening results, or an attestation of compliance with background screening, in the personnel records.

On at 3:30 PM, Ex-Employee D called the Administrator to confirm that all of the employees had their level II screenings in their files, but none were found on site.

Unclassified

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on observation and record review, the facility failed to maintain an accurate roster of its employees in the Background Screening Clearinghouse database.

Findings:

During inspections on , , ad between 8:30 am and 3:00 pm, observed the Administrator and Employee C at the facility providing meals, medication and other services to residents.

A review of the facility's roster in the Background Screening Clearinghouse database showed that no employees were listed as currently working there. The Administrator was not listed. Employee B was listed as discontinued in 2016. Employee C was listed as discontinued in , 2008. Employee D was listed as discontinued in , 2016.

Unclassified

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

Based on observation, interview and record review, the facility failed to ensure that persons providing

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care to residents, who had access to resident personal property and living areas, had an eligible Level II Background Screening (for Non-Staff E and F).

Findings included:

On at 7:05 am during a relicensure visit, five residents and two unidentified, non- staff persons were observed. Non Staff F was sleeping in # , in the resident #3. Non-Staff E was living in # , in the Resident #7. Staff C reported, she slept in the 'staff only' resident #7, who was hospitalized.

On at 9:35 am when asked if she provided care to residents, Non- Staff E stated, she only helped the residents if they needed it. At approximately 10:00 am, observed Non- Staff E in the facility kitchen cooking breakfast for the residents. At 12:30 pm, observed Non- Staff E prepare and serve lunch to Resident #5. Non-Staff E stated, she was a volunteer and during the days and evenings, she helped the female residents with bathing and adult brief changes. A review of the personnel records and of the Background Screening Clearinghouse Database showed for Non-Staff E, there was no personnel record, eligible level two background screening, or documentation of nutrition and safe food handling or any other training.

Interview on at 8:30 am, Resident #2 stated, Non-staff E did most of the cooking and cleaning in resident , and she fed the female residents if they needed help at mealtime.

On at 9:00 am, observed Staff C and Non-Staff E preparing breakfast for residents. Non-Staff E then served breakfast to Resident #4 in her .

On at approximately 12:00 noon, observed five residents and two Non- Staff persons in the facility. No staff was present. Non-Staff E stated, "Staff C stepped out for a moment. No staff is here. They've been gone for about a half hour. They went to get something for residents to eat."

Interview on at 12:05 pm, Resident #4, who was paralyzed and a right leg amputee, stated, "I don't get out of bed. Non Staff E changes my incontinence briefs. The owner and Non-Staff E give me baths and my medications. Non Staff E gives me food. My guardian comes by sometimes, but I don't remember their name." Non-Staff E was observed to pull back the bed covers on Resident #4 to show the resident's adult brief. Non Staff E stated, "It is dry. I change it for her."

On at 12:11 pm, Resident #6 was observed laying in bed in # . Resident #6 had a half full

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On . . . at 12:20 pm, Non-Staff E stated, she had been mistaken, and Non-Staff F was in charge until the staff returned. Non-Staff F stated, he had been living and working at the facility for many years, and that he sometimes worked at a couple of other facilities.

On at 12:25 pm, the Administrator returned to the facility and stated, she had left to take Staff C to the doctor. She stated, Non-Staff F was trying to get his background screening and his training's back because he used to work at the facility long ago. She further stated, he now works at the facility overnight to help with medications and resident care.

On at 12:33 pm, Non-Staff F was asked what he did at the facility, and he stated, "I do everything. I help them dress and take a showers. I clean the house. I don't cook, but I would if I had to. He stated, "he helped his shower and that he helps the other men in the house."

Unclassified