STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967063	**02/16/2017**
NAME OF PROVIDER OR SUPPLIER **GOOD STAND HOME CARE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **721 NW 13 AVENUE** **MIAMI, FL 33125**	

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

0000 - Initial Comments

A Standard Biennial Survey was conducted on . Good Stand Home Care Inc License #11262 had the following deficiencies found at the time of the survey:

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on interview and record review, the facility failed to provide documentation of an updated health assessment for 1 out of 8 sampled residents (Resident #1). The health assessment did not specify that Resident #1 was self-administering .

Findings include:

In an interview with the Administrator on at 10:40 AM, he stated that Resident #1 had a prescription for self-administration of . He further stated that a nurse came to the facility to instruct Resident #1 on how to monitor her sugar and on how to self-administer .

A review of a Resident #1's file revealed two prescriptions from a physician, which stated that the resident is able to self-administer . The prescriptions dates were and .

A review of Resident #1's health assessment, dated , indicated that the resident needed help with taking her medications. In Resident #1's health assessment, the checkbox for "needs assistance with self-administration of medications" was marked. There were no additional comments on this health assessment to describe Resident #1's ability to self-administer .

In an interview with Resident #1's physician on at 12:50 PM, he stated that he had assessed the resident and determined that she is fully competent and knows how to self-administer .

Class III

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

Based on interview and record review, the facility failed to contact the resident's guardian when the resident exhibited a significant change for 1 out of 8 sampled residents (Resident#1). The facility failed to notify the resident's guardian of a hospital admission and did not provide the hospital with the letter of guardianship for the purpose of consents.

Findings include:

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A review of Resident#1's file revealed that the resident had a legal guardian appointed on .

A review of Resident#1's file revealed a letter from the guardianship program dated that stated, "The guardian must be notified if the ward is transferred to a hospital or other facility. Furthermore, the ward should be transferred to an appropriate hospital that is nearest to the facility unless the guardian and the physician agree otherwise and letters of guardianship must accompany him/her. In order to facilitate routine or emergency communications related to the above named ward, the guardianship program of [county location], maintains a 24 hour answering service".

A review of Resident#1's hospital records revealed that the resident was taken to the hospital on , was admitted to the hospital on and was discharged from the hospital on .

During an interview with Resident#1's guardian on at 12:55 PM, she stated that she was not notified by the assisted living facility regarding Resident#1's hospital admission on , during Resident#1's stay at the hospital until .

During an interview with Resident#1's guardian on at 12:55 PM, she stated that the protocol for a hospital admission of a resident who has a guardian is for the assisted living facility to contact the guardianship program and subsequently, a guardian would go to the hospital. Additionally, she stated that the facility would need to send a letter of guardianship to the hospital and the hospital would then fax the letter of guardianship to the resident's guardian to get consents for services and procedures during the hospitalization. Resident #1's guardian stated that no staff from the guardianship office went to the hospital and that there was no documentation faxed to the guardianship office regarding Resident#1's hospital stay from to .

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on interviews and observation the facility failed to honor 1 out of 7 sampled residents resident's rights to be treated with dignity and respect. The facility failed to ensure that qualified, linguistically competent staff were available to supervise and communicate with Resident #7's family members.

Findings included:

On 2:30 PM observed outside in common , the facility had a television area and the television was playing in Spanish throughout entire survey.

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On at 2:11 PM, Resident #6's mother revealed she was not able to communicate with staff regarding the resident's condition because they do not speak English, and getting the resident on the phone is difficult because the staff is not able to understand her when she calls. She also stated Resident #6 has complained about not being able to watch television because it is only in Spanish all day.

On at 1:10 PM, Staff B stated "I will like to learn how to speak English better."

On at 2:55 PM,Staff A stated "you are right. If they call here, there would not be anyone to communicate with them."

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation and interview the facility failed to follow the procedure outlined by the state when assisting 5 out of 5 sampled residents with self-administration of medications. The staff failed to give medication to residents during the window time of one hour before or one after the medication was is prescribed, failed to hands, and did not ensure the residents took the medications (Resident #1, #2, #3, #5, and #6).

Findings included:

On at 7:11 AM arrived to facility and was greeted by Staff B.

A review of the medication observation record (MOR) revealed medications prescribed at 9:00 AM were already initialed at 7:16 AM.

A Review of the medication record revealed Resident #2 was prescribed 120 MG 1 tab daily, , 2 Mg 1 tab daily, 25 Mg 1 tab daily, 50 Mg 1 tab daily, D3 1 tab daily, Sarelto 20 Mg 1 tab daily, , 1 Mg 1 tab twice a day at 9:00 AM.

A Review of the medication record revealed Resident #3 was prescribed Glipized 5 Mg 1 tab daily, 25 Mg 1 tab daily, 100 MG 1 tab daily, - eye drops 1 drop on each eye 2 times a day, and 50 Mg 1 tab daily at 9:00 AM.

A Review of the medication record revealed Resident #5 was prescribed Cal-Gest Chew tabs 500 MG 1 tab daily, , 75 Mg, 1 tab daily, 20 Mg 1 cap daily, D3 1 tab daily,

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20 Mg 1 tab 2 x a day. . . . . , - . . . , 25-100 MG 1 tab 3 x a day at 9:00 AM.

On at 7:16 AM observed the medication packets, during medication reconciliation of the . . . . packets and MOR, showed the medication pills for Resident #2, #3, and #5 were not in the packet.

On at 7:13 AM Observed Resident #3 dropped his medication on the floor; the staff picked up medication and handed the medication to the resident.

On . . . at 8:06 AM observed, Staff B assist Resident #1 with self-administration of medications, observed
Staff B did not . . . . hands, she took medication from packet and put all medications in a cup, medication cup on the floor, staff picked up medication cup and placed all medications in cup, and gave the medication to the resident, she stated a couple of names of the medications to resident, and the resident got up to get water. The resident was left alone with the medications while staff went to put medication away in closet, the staff did not ensure resident took medications, and proceeded to sign medication book.

On at 8:24 AM observed Staff B assist Resident #6 with self-administration of medications, observed Staff B did not . . . . . hands, she took out . . . . pack and put all medications in the same used cup, staff stated name of medications to resident as she put them in cup. Resident took cup and took all medications, staff handed a cup of water, she waited for the resident, put medication away and proceeded to sign medication book.

On at 2:06 PM, interview with Staff B stated "What happened this morning is that he put the medication in his mouth and then he spilled it out, with Resident #6 when I came back I saw the cup was empty that how I knew he took his medication. I know it was wrong and that was my mistake."

Class III

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

Based on record review and interview the facility failed to provide documentation of a written statement from a health care provider stating that the individual does not have any signs or symptoms of communicable for 5 out 5 sampled staff (Staff A, B, C, D, E, and F).

Findings included:

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A review of Staff A, B, C, D, and E's employee file showed that there was no written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable .

On at 1:20 PM, Staff A stated "I did not have the statement in their files because I was never told I had to have a copy of that, I have never been told that by anyone, I was not aware that was a requirement."

Class III

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

Based on observation, record review and interview, the facility failed to maintain an accurate written work schedule that reflects its 24 hour staffing pattern.

Findings Included:

On at 7:11 AM arrived to facility and was greeted by Staff B. Observed that Staff B was the only staff available to residents.

A review of the staff schedule revealed Staff B was scheduled to work 8:00 AM to 4:00 PM and Staff C was scheduled to work 7:00 AM to 4:00 PM.

On at 9:45 AM, Staff A stated, that Staff C was scheduled for 7:00 AM to 4:00 PM, but the staff called out sick and he called another staff to cover and they were not able to come.

Class III