STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968818	03/01/2017
NAME OF PROVIDER OR SUPPLIER **LIVING CARE FACILITY INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **10355 SW 38 TERR** **MIAMI, FL 33165**	

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

0000 - Initial Comments

A Standard Biennial Survey was started on and concluded on at Living Care Facility License #12671. The following deficiencies were found at the time of the survey.

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

Based on observation, record review, and interviews, the facility failed to provide care and supervision appropriate to the needs of 1 of 6 sampled residents (Resident #1) in order to prevent resident resulting in injuries. The facility failed to appropriately assess for changes in condition, and failed to notify the health care provider when a resident exhibited a significant change for 1 of 6 sampled residents (Resident #1).

Findings included:

During the facility tour resident #1 was observed on at 9:10 AM and was observed to have a right eye. The to the right caused the resident's eye to be closed. The resident's right area was, discolored with redness and . Dry stains with scaring was above the residents right eyebrow. On the left side of the residents forehead, there was dried , and the resident's lips appeared .

Resident #1 was interviewed on at 9:10 AM, and the resident #1 reported, she in her , on the floor and hit her face on the floor.

During interview with the Administrator it was reported on at 09:48 AM, 911/emergency services was called, but resident #1 refused to go to the hospital when fire rescue arrived. The Administrator reported, the resident refused to be transported to the hospital.

During the review of resident #1's health assessment dated , the documentation revealed, the resident had a medical history of , , , and Mood . Resident #1's health assessment documented the resident was independent with ambulation, dressing, eating, self-care/ , toileting, transferring and supervision with bathing. The assessment documented, the resident would need assistance with medications.

During the review of resident #1's progress notes dated on revealed, the "resident was acting good at the moment." On progress note revealed, "resident continue act the same, she complaint about the pain. She took a lot of meds (medications). The doctor knows, my concern that sometimes she very weak. She is under observation." There were no other notes or observations in the

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residents chart at the time of the survey on . It was noted, the facility failed to document any changes in the resident's condition after the , which resulted in injuries in . The facility also failed to notify Resident #1's doctor or ensure the resident received medical treatment after the .

During interview with the Administrator on at 10:00 AM. The Administrator reported, Employee B called her, and no specific time was given on the time the call was received to come to the facility because of an emergency with Resident #1. The Administrator reported, she came to the facility, observed the resident's face and called 911, but the resident told her not to call 911 because she did not want to go to the hospital. The Administrator was asked, what type of emergency services was given to resident #1 for her injuries. There was no response to the question, but the administrator finally stated, the doctor was called and advised of the incident. The Administrator was not able to provide any documentation that the doctor or 911 was called about the injuries resident #1 had sustained. The Administrator was asked to contact a physician to have Resident #1's injuries observed on her face assessed by a physician.

Additional record review revealed, the facility contacted the physician for Resident #1 after surveyor request. This record review revealed the doctor ordered an X-ray/CT (Computed Tomography) Scan for Resident #1 on . It was noted, the X-ray/ was not completed until (five days after the order).

Record review of Resident #1's hospital records on showed the resident was transferred to the hospital on after being found on the assisted living facility's floor from having a . The hospital records documents, "present to ...medical center after transient episode of loss of . I saw the patient the day of after admission, she refused and she denies any loss of and states that she was transferred here for severe pain." The facility did not have any documentation in the chart from the incident.
The resident was transferred to the hospital on for, " , ." The hospital findings revealed, "a hematoma on the lateral margin on the right orbit with mild preorbital hematoma and soft tissue ."

On at 1:30 PM during a phone interview with the Administrator, it was revealed the Administrator did not call 911 for the Resident after she . The Administrator was also asked about the lack of notes regarding Resident #1's . The Administrator reported, no notes were completed for the resident's chart.

During a phone interview with Doctor #1 on at 1:15 PM it was reported, the resident was given an examination and was given a prescription for the services she needed at that time until her

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appointment on . Doctor #1 reported, resident #1 was a new patient and has only been her patient from until currently . Doctor #1 reported, she knew of a couple of other times that Resident #1 had in the facility around the month of , 2017 and the current on . Doctor #1 reported, she was only attending to the resident for her current hospitalizations and had nothing to do with her medications for .

During interview on at 1:00 PM, the Administrator was asked, what precautions were put in place to prevent Resident #1 from falling. The Administrator reported, Resident #1 one time and that was on . The administrator was informed about another identified in the residents hospital records while the resident was in the facility. The Administrator then admitted, Resident #1 had a few more times, but she did not know the times or dates for the since she did not keep notes in the residents chart.
The Administrator reported she mentioned the to Resident #1's doctor (#1). The administrator reported, doctor #1 told her Resident #1's medications could be the problem because it can cause her to be unbalanced when walking around the facility. The Administrator reported, the medications made resident #1 drowsy. The Administrator reported, she was going to stop resident #1 from taking the medication (, 15 mg tab) if it continued to make her , and off balance. The Administrator could not provide the written doctors order to discontinue the medication.

Review of Resident #1's medication observation record for , 2017 revealed, the resident receiving , three times a day, at 7:00AM, 3:00PM, and 11:00PM.

Class II

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review and interview, the facility failed to have 1 of 4 sampled employees (D) trained in safe food handling within 30 days of employment.

Findings included:

Record review revealed Employee D, hired on , who worked the evening/night shift at the facility did not have safe food handling training within 30 days of employment.

During interview with the Administrator on at 2:00 PM revealed, she scheduled an appointment for the training.

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Class III

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

Based on observation, record review, and interview, the facility failed to file a one day incident report for 1 of 6 sampled residents (Resident #1) who at the facility and had injuries.

Findings included:

During the facility tour resident #1 was observed on at 9:10 AM and was observed to have a right eye. The to the right caused the resident's eye to be closed. The resident's right area was, discolored with redness and . Dry stains with scaring was above the residents right eyebrow. On the left side of the residents forehead, there was dried , and the resident's lips appeared .

Resident #1 was interviewed on at 9:10 AM, and the resident #1 reported, she in her , on the floor and hit her face on the floor.

During record review it was revealed, the facility did not complete or submit a one day incident report to the Agency for Health Care Administration regarding Resident #1's .

Class III