STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922174	R 02/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA'S ELDERLY HOMECARE, INC	**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 revisit survey was conducted 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 observation, record review and interview, the facility failed to ensure that one of six sampled residentsadmitted to the facility met the admission criteria (#2) .

Findings included:

On at 9:15 A.M., observed Resident #2 seated on the sofa in the living .

A review of Resident #2's health assessment dated showed diagnoses of , mild and persistent, caries, , female stress incontinence, major , , , disc, with /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 document identified that the individual's needs could not be met in an assisting living facility and that the resident needed 24 hour , supervision. The facility did not have a new health assessment on record.

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 she is not an elopement risk." There was no documentation that an elopement assess was done at the time of the admission.

During an interview on at 11:08 A.M. the Administrator stated that he called Resident #2's primary doctor to evaluate resident. He said "They told me that she has issue with her insurance. I called the insurance company and they told me that the physician had to submit the request for the approval." The Administrator acknowledged that there was no documentation in the record that this attempt to reach the physician was made.

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Uncorrected
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 ensure that 1 resident out of 6 (#3) met the criteria for continued residency in any licensed facility, The resident did not have a face-to-face medical examination by a health care provider when the resident exhibited a significant change.

Finding included:

A review of Resident #3's health assessment (AHCA form 1823) dated showed that the Resident required 24 hour nursing or care.

During an interview on at 11:27 a.m. interview with the Administrator he reviewed the health assessment of Resident #3. He stated there had been a mistake.

Uncorrected
Class III

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

Based on interviews and record review, the facility failed to maintain daily observation and awareness of the general health, safety, and physical and emotional well-being by designated staff of the activities of the residents, for 1 of 6 sampled residents (#1). Resident #1 was in Orlando, FL after a discharge from the hospital for a episode where he was missing from the facility. The resident was transferred back to Miami and Resident #1 did not return to the facility. 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 in a timely manner when the resident missing from the facility.

Findings included:

During an interview on at 10:09 A.M. the Administrator stated, "I'm technically and legally holding the bed for Resident #1 but he is not at the facility, yet. Resident #1's legal guardian informed me over the phone that Resident #1 was discharged from the hospital in Orlando and he was going to arrange the transportation for the resident to return to the facility. Our conversation was on . After that the transportation person (driver) called us and talked to Staff B over the phone, stating that she was at the train station waiting and couldn't identify Resident #1 because no information was given

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to her. For example, what clothes that the resident was wearing. We did not hear anything from his return and we called the legal guardian. We did not receive any call from the hospital, and we did not have any communication with the hospital. On a case manager from legal guardian came to the facility to visit Resident #1 and at that time he realized that resident never returned to the facility. He did not know where he is. The Administrator stated that legal guardian spoke to Resident #1 when he arrived at the Miami train station on . A case manager told me that he will go back to his office and review the resident's record. He told me to give him a couple of days to review his record and we never heard from him again; he never got back to me. On I called Resident #1's legal guardian office and I spoke to another person and she informed me that I had to make another missing person report, and I did."

Record review of Resident #1's file showed health assessment (AHCA form 1823) dated , had diagnoses of , , type. The resident need assistance with self-administration of medication. Medication observation record (MOR) review 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).). There was 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 was found in Resident #1's progress notes. Review record showed that a new police report was done on .

A review of the facility's elopement policy, developed after Resident #1's initial elopement on , showed that the facility's steps in case of elopement were to advise police, inform the family, inform the health care provider, search a large area, file a missing person's report with the police, and complete a one day and 15 day adverse incident report. The policy also stated that elopements and attempted elopements would be recorded in the residents' files.

A review of all resident files and the facility's elopement book showed that no residents had an elopement risk assessment completed.

During a phone interview on at 10:55 a.m., a case worker from the legal guardian's office stated, "I'm not familiar with this person or client, give a minute to read the note". He returned to the call and stated, "Last visit was ; his case worker arranged on a transportation company to pick the Resident up. We have not seen the Resident since then. On , we attempted to contact the facility but no one answered the phone. On we received a call back from facility Administrator. On we received a second called back from the facility to see if we'd heard from

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the resident. We've been in contact with the Administrator but the person did not show up."

Uncorrected
Class II

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

Based on record review, and interview, the facility failed to provide a safe and decent living environment for residents.

Findings included:

Pests were observed at the facility on at 9:28 am. A review of facility records found that the last pest control invoice was date on . The facility did not have documentation that facility had a contract with any company to fumigate the facility, or that any other action had been taken to correct the situation since .

During an interview on at 11:46 a.m. the Administrator stated "I'm in contact with one company to see if they can start tomorrow."

Uncorrected
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) who was missing from the facility and later found in Orlando, FL. The facility held a bed placement for the resident, who was discharged from the hospital and never arrived at the facility.

Findings included:

Resident record showed two case reports one dated and the other one dated , when a missing persons' report was filed with the police when Resident #1 was missing.

A review of hospital records for Resident #1 showed on that the resident was hospitalized in Orlando under , and had been off his medications.

During an interview on at 10:09 A.M. the Administrator stated that he was technically and

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legally holding the bed for Resident #1, but the resident was not at the facility yet. He stated Resident #1 was transferred from Orlando to Miami but never arrived at the facility. Resident #1 was missing again.

On at 10:39 a.m. the Administrator stated "I do not have documentation in writing. I do not have confirmation that a 1 day report was done on for the incident dated . I did not fax or file a second incident report with the agency."

A review of the AHCA's Incident Report Database revealed there was no adverse incident report completed for Resident #1.

Uncorrected
Class III