STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966712	04/24/2017
NAME OF PROVIDER OR SUPPLIER **M & Y CARING AND LOVING ALF, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **22712 S W 103 COURT MIAMI, FL 33190**	

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

0000 - Initial Comments

Complaint (CCR #2017001777 & 2017001794) Survey was conducted on , 2017 and concluded on , 2017. M & Y Caring and Loving ALF, Inc had the following deficiencies identified at time of the survey:

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

Based on record reviews and interviews the facility failed to properly assess 1 of 6 (Resident #6) sampled residents who did not meet continued residency criteria. Resident #6 was admitted the hospital with untreated , . Resident #6 had 10 , , 4 of which were unstageable, with , at admission to the hospital. The resident ultimately in the hospital. The facility also failed to ensure that 1 of 6 (Resident #6) sampled residents had updated and completed health assessments.

Findings included:

Record review found Resident #6's facility progress notes dated stated, "I, Staff C, notice in Resident #6 red spots in the low back area. I immediately started putting cream & change his position several times a day on the bed." The notes dated stated, "after seeing Resident #6 the red spots on the back, & consulted with professional (nurse & doctor) I contacted Hospice. They came & examined Resident #6 & filled out all necessary papers to enroll him with hospice." A further review of records showed that the resident was not admitted to hospice until , and never received hospice care because he was admitted to the hospital on .

The hospital records received on for Resident #6 stated:
"The patient is a male, who was initially admitted to hospital on , 2017, with . The patient was residing at an ALF. He was also and was found to have acute , with acute kidney injury and with . The patient was noted to have protein- calorie with of chronic . The patient was admitted to the hospital and underwent medical evaluation and management. The patient's condition improved; however, the patient continued to have decreased oral intake and protein -calorie . was consulted for tube placement."

The Care Patient Assessment showed:
#1 located on the sacrum; , length 15.0 cm, Width 8.5 cm, Depth 0.6 cm, Drainage Malodorous ; Drainage Amount: Large; Surrounding Tissue: Intact, 70% with 30% pink tissue.
#2 located on the left hip; Stage: unstageable (tissue), length 10.6 cm, Width 7.5

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cm, Depth 0.1 cm, Drainage: ; Drainage Amount: Small; Surrounding Tissue: Reddened with 100% tissue.

#3 located on the right hip; Stage: unstageable (tissue), length 7.5 cm, Width 5.0 cm, Depth 0.1 cm, Drainage: ; Drainage Amount: Small; Surrounding Tissue: Reddened with 100% tissue.

#4 located on the left lower Back; Stage: unstageable (tissue), length 4.2 cm, Width 3.7 cm, Depth 0.1 cm, Drainage: ; Drainage Amount: Moderate; Surrounding Tissue: Intact with 80% tissue.

#5 located on the right lower back; Stage: unstageable (tissue), length 3.3 cm, Width 2.2 cm, Depth 0.3 cm, Drainage: ; Drainage Amount: Small; Surrounding Tissue: Intact.

#6 located on the left foot; Stage: suspected deep tissue injury, length 0.5 cm, Width 0.7 cm, Drainage: None; Drainage Amount: Small; Surrounding Tissue: Intact.

#7 located on the left heel; Stage: suspected deep tissue injury, length 0.5 cm, Width 0.5 cm, Drainage: None; Surrounding Tissue: Intact.

#8 located on the left ankle; Stage: suspected deep tissue injury, length 2.0 cm, Width 1.5 cm, Drainage: None.

#9 located on the right ankle; Stage: suspected deep tissue injury, length 0.5 cm, Width 1.4 cm, Drainage: None.

#10 located on the left shoulder; Stage: suspected deep tissue injury, Drainage: None.

Interview on at 2:45 PM with Staff B (owner) stated, "Resident #6 went to the hospital and he needs more care than the facility could provide so he was transferred to a skill nursing facility." A review of the facility's records showed that the resident received no medical care while at the facility for at least 27 days.

Record review for Resident #6 file showed he was admitted to the facility on .
Review of facility files found that there was no documentation that the resident received a health assessment within 30 days of admission. The health assessment found was dated and was addressed to Resident #6's previous assisted living facility. There was also no documentation of Resident #6 having an updated health assessment that documented his change in condition such as his decline in activities of daily living and multiple . The health assessment dated had the following diagnoses , ( ), Cerebellar Ataxia, Chronic , P. , , Non- Dependent Type II (II), , , , ( ), , and , . Resident is alert and oriented X2. Resident needed assistance with all activities of daily living. Resident needs assistance with self-administration of medications.

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Interview on at 2:30 PM Staff B stated, "He (Resident #6) used to be all the time in the wheelchair. Most of the day. One day he was moving the wheelchair when he was entering the he almost and hit the front of his head area, the eye and the eyebrow area, on the frame of the door. He did not go to the hospital because it was like a scratch. We did not think to take him to the hospital. We had worked the whole week. The other staff at that time worked only the weekend. Thank God it happened with me, Staff C was at the facility. The son knew he hit his eye. We told him. It was and scratched. The next day it went down. It was our mistake. We did not send him to hospital. We did not call the ambulance. We did not report it to agency. He needed assistance with everything except eating. We had to help him with eating. He was eating very well. He was taking one medication. Well, in he started getting the pressure sores. Maybe like around the 15th through the 20th. We did not call hospice. We were waiting for the son to come and sign the hospice paperwork." When asked why would he need hospice when you could send him to the hospital for a doctor to check him? Staff B stated, "It was our mistake. We called the hospice and they came and evaluated him and accepted him, but needed the son to fill out the admission paperwork. But he took more than 25 days for him to sign the papers."

The hospice records received on showed on Resident #6 diagnosis of ; secondary diagnosis Cachexia. The admissions orders/ hospice certification for the initial plan of care documented his diagnosis description . Resident #6's pre-admit evaluation stated, the reason he is enrolled in hospice was "because of declining functions, weight loss, and Cachexia. His current weight is 110 lbs.; 3-6 moths 140 lbs. The skin he has currently is (Right Flank), (Left), (left flank), (right), and (sacral spine)." The General Comments stated, "Bedbound, losing weight, having difficulties swallowing fluids, coughing with water, pureed diet only, declining functions.

A review of Merck Manual online revealed that "Cachexia is wasting of both adipose tissue and muscle. It occurs in many conditions and is common with many when remission or control fails. Affected patients may lose 10 to 20% of body weight." Some "treatments can mitigate Cachexia and improve function. Cachexia is easy to recognize, primarily by weight loss, which is most apparent with loss of muscle in the face. The loss of fat increases the risk of over bony prominences."

Class II

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

Based on observation, interviews, and record reviews, for at least 27 days, the facility failed to obtain

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medical care for 1 of 6 sampled residents (#6) to prevent further which resulted in ten pressure sores, some of which were unstageable. The facility did not maintain a written record of a significant change, and did not contact the family and health care provider for the , . These factors resulted in Resident's #6 hospitalization. The resident's wounds became , and the resident ultimately in the hospital The facility also failed to provide care and services from qualified staff to meet the needs of a census of 6 residents.

Findings included:

1. A review of records from another state agency's investigation showed that staff at the facility were aware of Resident #6's wounds (10 wounds including 4 unstageable wounds), but did not seek out timely medical assistance. Inadequate supervision was verified. The report stated Resident #6 had bedsores on both hips and on his back.

Record review showed Staff A, B, C, or D were not licensed personnel. Further record review found Resident #6's facility progress notes dated stated, "I, Staff C, notice in Resident #6 red spots in the low back area. I immediately started putting cream & change his position several times a day on the bed." Record review found when staff from the facility identified that Resident #6 had multiple wounds on his back, hip, and shoulder that doctor was not notified.

Record review showed that Resident #6 received no care from a qualified health care provider for at least 27 days.

Per hospital records, on Resident #6 presented to the hospital bedbound and non-verbal. The facility did not have any documentation that Resident #6's family members or doctor were notified of his change in condition.

2. During tour on at 9:30 AM, and on at 1:30 PM found Staff D alone with a census of six residents.

Record review found the posted staff schedule had two staff members listed. Staff B was scheduled to work 7:00 PM to 7:00 AM and Staff C was scheduled to work 7 AM to 7 PM. Observations during the survey found both staff members were not present upon arrival on at 9:30 AM and were not at the facility on at 1:30 PM. Staff D was not listed on the schedule.

A review of the staff schedule showed that there was no documentation reflecting that the facility maintained the required 212 hours per week to care for six residents. The facility did not have

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documentation to show the actual hours that Staff A, B, C, or D worked.

Interview on at 3:00 PM Staff B acknowledged the staff schedule did not reflect the staff working at the facility, and stated he would correct it.

Record review found that four of six the residents (#1, 2 and 3 and 4) had mental health conditions, needed assistance with medications, and had precautions. Record review found Resident #1's health assessment dated had a medical history of diagnosis. Resident #2's health assessment dated had the following diagnoses: , , Phase, and the resident is an elopement risk. Resident #3's health assessment dated documented that the resident had a medical history of , . Resident #4's health assessment dated had the following diagnoses: Acute , , , , , I , and precautions.

A review of Staff D's personnel record showed that there was no documentation of Limited Mental Health Training.

Interview conducted on at 1:30 PM Staff D stated, "I think he (Administrator) may come since the couple is not here. I don't know the Administrator. I'm new. I more communicate with the couple (referring to the facility's owners). They are on vacation right now. I will be here until they come back which is next Tuesday."

Phone interview on at 2:30 PM Staff B stated, "We are in Colorado, got here two hours ago." During survey process conducted on to , the Administrator did not participate in the survey process and was not able to be reached by telephone.

Class II

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

Based on record reviews and interviews the Administrator failed to maintain the general oversight of the daily operation of the Assisted Living Facility. The Administrator also failed to ensure that qualified staff were providing adequate care and services to the residents and that resident records were completed for 1 of 6 (Resident #6) sampled residents.

Findings included:

Record review found Resident #6 did not have a completed health assessment at the facility from admission on until his admission to the hospital on . The Administrator did not ensure

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that residents at the facility had completed and updated health assessments at admission or when there was a change in condition. The facility failed also to have weights recorded for Resident #6. The last weight recorded for the resident was in , 2016. The facility did not have any notes regarding Resident #6's weight loss. Hospice admission records stated the Resident #6's current weight was 110 pounds and that he'd lost 30 pound within the last few months. There was no documentation that the Administrator or his designee ensured that Resident #6's doctor was contacted regarding the weight loss and that the facility had documentation regarding this matter. Facility records show that on Resident #6 had wounds observed on the lower back area and unlicensed staff at the facility placed "cream" on the . There was no documentation that the Administrator or his designee ensured that Resident #6's received care or other medical treatment for at least 27 days.

Hospital records show Resident #6 was admitted to the hospital in , 2017. The Resident had 10 , .

The Care Patient Assessment:

#1 located on the sacrum; , length 15.0 cm, Width 8.5 cm, Depth 0.6 cm, Drainage Malodorous ; Drainage Amount: Large; Surrounding Tissue: Intact, 70% with 30% pink tissue.

#2 located on the left hip; Stage: unstageable (tissue), length 10.6 cm, Width 7.5 cm, Depth 0.1 cm, Drainage: ; Drainage Amount: Small; Surrounding Tissue: Reddened with 100% tissue.

#3 located on the right hip; Stage: unstageable (tissue), length 7.5 cm, Width 5.0 cm, Depth 0.1 cm, Drainage: ; Drainage Amount: Small; Surrounding Tissue: Reddened with 100% tissue.

#4 located on the left lower Back; Stage: unstageable (tissue), length 4.2 cm, Width 3.7 cm, Depth 0.1 cm, Drainage: ; Drainage Amount: Moderate; Surrounding Tissue: Intact with 80% tissue.

#5 located on the right lower back; Stage: unstageable (tissue), length 3.3 cm, Width 2.2 cm, Depth 0.3 cm, Drainage: ; Drainage Amount: Small; Surrounding Tissue: Intact.

#6 located on the left foot; Stage: suspected deep tissue injury, length 0.5 cm, Width 0.7 cm, Drainage: None; Drainage Amount: Small; Surrounding Tissue: Intact.

#7 located on the left heel; Stage: suspected deep tissue injury, length 0.5 cm, Width 0.5 cm, Drainage: None; Surrounding Tissue: Intact.

#8 located on the left ankle; Stage: suspected deep tissue injury, length 2.0 cm, Width 1.5 cm, Drainage: None.

#9 located on the right ankle; Stage: suspected deep tissue injury, length 0.5 cm, Width 1.4 cm, Drainage: None.

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#10 located on the left shoulder; Stage: suspected deep tissue injury, Drainage: None.

Interview on at 9:30 AM, Staff B stated he is not the Administrator "because I could not pass the test."

During survey process conducted on to , the Administrator listed did not participate in the survey process and was not available by telephone.

Observations on found the staff schedule posted had Staff B working 7 PM to 7 AM and C working 7 AM to 7 PM. The Administrator was listed as 'on call'.

Interview on at 1:30 PM Staff D responded when asked about the Administrator, "I think he may come since the couple is not here. I don't know the Administrator. I'm new. I more communicate with the couple. They are on vacation right now. I will be here until they come back which is next Tuesday."

Record review found that Staff D was hired on , as a caregiver for the residents.

Class II

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 complete and submit 1 day initial adverse incident report and 15 day full incident report to the agency for one out of six (#6) sampled residents that sustained injuries from a .

Findings included:

Interview on at 2:30 PM Staff B stated, "He (Resident #6) used to be all the time in the wheelchair. Most of the day. One day he was moving the wheelchair when he was entering the he almost and hit the front of his head area, the eye and the eyebrow area, on the frame of the door. He did not go to the hospital because it was like a scratch. We did not think to take him to the hospital. We had worked the whole week. The other staff at that time worked only the weekend. Thank God it happened with me, Staff C was at the facility. The son knew he hit his eye. We told him. It was and scratched. The next day it went down. It was our mistake. We did not send him to hospital. We did not call the ambulance. We did not report it to agency.

Record review found the facility failed to report Resident #6's to the agency.

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Class III