STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967079	**04/25/2017**
NAME OF PROVIDER OR SUPPLIER **L & B SOLUTION CARE, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **565 NE 137 STREET** **MIAMI, FL 33161**	

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

0000 - Initial Comments

A complaint Investigation Survey CCR#2017001700 and 2017002215 was conducted on and completed on . L & B Solution Care, Inc. with a Limited Mental Health component license# 11186 had the following deficiencies found at the time of the survey:

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

Based on observation, record review, and interview, the facility failed to ensure the appropriateness of continued residency for two out of six sampled residents (Residents #1 and 3). Resident #1 was hospitalized for Hypernatremia, , significant weight loss, and functional decline. Resident #3 was unable to ambulate, eat or take medication without assistance, and required total care. The facility also failed to ensure that the health assessment was accurate for Residents # 1 and 3).

Findings included:

1)

On at approximately 2:00 PM, Resident#1's medical providers stated that on , Resident #1 forward on her face while sitting on the couch at the facility. The resident received an eye laceration and was still hospitalized at the time of the interview.

A review of the facility's records showed that there was no documentation of the resident's or hospitalization on .

In an interview on at approximately 2:10 pm, Resident#1's medical providers stated that on the resident was found , and was hospitalized. The provider further stated that they provided food and nutritional supplements to the assisted living facility for the resident. During a 2017 visit with the dietician, the resident was found to be 15.99 pounds under weight, weighing 90 pounds, which was down from 92.6 pounds in . The provider stated that they were not informed that the resident had a at the assisted living facility in , or that she was hospitalized. The provider stated that they'd had meetings with the facility to express concerns about the living environment and care of several of their residents who were living there, including Resident #1.

A review of hospital records showed that Resident #1 was hospitalized on at 14:45 PM for acute hypernatremia, , and significant weight loss and functional decline. The resident was diagnosed with secondary to decreased oral intake.

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A review of the facility's record for Resident #1 showed progress notes dated through reflecting a decline in the resident's condition, where the resident was observed lying in bed all day, listless, over several days. The record states that on , the resident was taken by emergency services after she had a and difficulty breathing, and that the facility staff contacted the resident's medical provider.

On at 2:10 pm, the medical provider stated that they were not contacted regarding the change in the resident's condition in 2016. The provider also stated that they were not informed that the resident had a and was taken to the hospital on .

A review of the (AHCA form 1823) Health assessment for Resident #1 showed that resident weight 91 Lbs. the health assessment was not dated. The resident was diagnosed with; , , with behavioral disturbance, , , . Physical limitations: wheelchair, nursing/treatment/ , service requirement: required assistance. All activities of daily living (ADLs) including; ambulation, bathing, dressing, eating, self-care ( ), toileting and transferring.

A review of the incident report database showed that adverse incident reports were not filed when Resident #1 was injured at the facility and transferred to a higher level of care in 2017, on , 2017, or on , 2017.

On at 11:30 AM, the Administrator stated that Resident #1 had been living in the facility since 2011 and that up to the time the resident was taken to the hospital, staff did not notice a change in her weight.

2)
On at 6:30 AM, observed Resident #3 lying in bed with half bed rails raised on both sides. The resident was unable to remove the rails or get out of bed without staff assistance.

On at 8:45 AM, observed Caregiver (B) and the Administrator lift Resident #3 from a wheelchair and place her the couch. The resident was unable to assist with her transfer. Caregiver (B) came with a plate of food and started forcing the food into the resident's mouth. The resident did not try to grab the spoon. The resident's appeared clenched shut, yet Staff B continued to attempt to shove the food into the resident's mouth. The resident turned her head away in an attempt to avoid the food.

On at 8:55 AM the Administrator stated that they had been feeding Resident #3 this way because this is the only way she would take her food. A review of the health assessment showed that

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the resident's diet order was for a Puree diet.

A review of Resident #3's record revealed: Diagnoses: with behavioral disturbance, . On all the ADLs she needs assistance with all ADLs, ambulation, bathing, dressing, eating, self-care( ), toileting, and transferring. The health assessment was not dated.

Further record review showed that resident went to her health care provider every Tuesday and Thursday where her was administrated and the rest of the days. The Administrator did not respond when asked who administered this medication to the resident at the facility.

A further review of Resident's #3's record showed that the resident had declined dramatically and no progress notes had been done about the resident's refusal to eat since , 2017. The record review showed that when Resident #3 was admitted, her weight was 120 Lbs.

On at 2:00 PM, Resident#3's medical providers stated that when the resident was weighed at the health care provider's office on her weight was 98 Lbs.

On at 8:54 AM, observed the Administrator giving Resident #3 liquid medication. It was put in a spoon, which was shoved directly into the resident's mouth.

In an interview on at 8:57 AM with the Administrator she stated regarding Resident #3's other medications, that they crushed the pills and gave them to the resident in a puree. Record review found no order for crushed medication.

In an interview on at 8:56 AM, the Administrator was asked if she or the caregivers were registered nurses and she stated that none of them were.

Class II

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

Based on interviews and record reviews, the facility failed to provide adequate supervision to 2 of 6 sampled residents (Resident #2 and #6). Resident #2 eloped two times in a three months period and the facility did not take any action to prevent this from happening again. The resident was found hospitalized in Pompano Beach a week after her first elopement. Resident #6 was observed walking

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around in the facility with feces visible on his clothing.

Findings included:

On at 12:00 PM Resident #2 eloped from the facility for over a week. She was found by police a bus stop in Pompano Beach, 27 miles away from the facility. A review of hospital records showed the resident was disoriented and and was taken to a hospital in another county under .

During an interview on at 8:55 AM the Administrator stated that the resident did not come to the facility that night, on , when she went missing. The Administrator further stated that a police report was done, and the health care provider was notified later. The Administrator stated that the hospital called the facility several days later and that's how the facility found out where the resident was.

During a phone interview on at 1:11 PM the hospital risk manager stated that Resident #3 was brought by police to a Broward county hospital because she was found at a bus stop very and disoriented, then she was transferred to their Mental Health Unit.

On at 07:03 AM the Administrator stated that the resident eloped on again on . She stated "We just assumed that she was at the store because she wanted to go to buy cigarettes. When she came from the program, the driver dropped her off in front of the facility and the resident just walked away."

Record review revealed that no incident report was filed for either elopement.

A review of Resident #2's record health assessment, (AHCA Form1823) showed, diagnoses of: , , , medication noncompliance. Elopement risk was marked NO, Activities of Daily Living (ADL) were all marked independent, except self-care; which the resident needed assistance with. There was no date on the health assessment. Further review of Resident #3's record revealed that no copy of her identification card was on file, and there was no documentation about her elopements.

On at 9:07 AM during an interview, Resident #3 stated, "I do not remember exactly how long I have been living in this place." The resident was very and was unable to be interviewed, even with the assistance of a Creole interpreter. The resident knew her name, but did not know the facility's address or telephone number. The resident stated that she had no identification card. Observation showed that the resident was not wearing any identification .

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A review of the facility's elopement policy showed the following:
All residents at risk of elopement or with a history of elopement shall be identified so that staff can be alerted to their needs for support and supervision.
What to do in case a resident does elope: A. identify resident, B. search immediate area, C. advise police 911, D. inform facility administrator or person in charge, E. inform family, F. inform health care provider, G. search a large area, H. after 24 hours - file missing person report with police authority, and get Identification (ID) for the resident within 10 days if they showed elopement behavior. Resident did not have an ID. I. fill out adverse incident report 1-day and fax to AHCA in Tallahassee within 24 hours, J. fill out adverse incident report 15-days and fax to AHCA in Tallahassee after 15 days have passed since the incident.

A review of facility record for Resident #2 showed that there was no documentation of an elopement assessment for any resident.

2)
On . . . . between the hours of 8:30 AM and 9:45 AM, Resident #6 was observed walking in the facility with feces stains on his clothing. The resident smelled like feces. Observed that staff were unable to assist the resident in bathing or changing clothes.

A review of Resident #6's health assessment, which was dated, showed d of; essential , major with aggressive symptoms and agitation, nonspecific , mild . Activities of Daily Living (ADL) assessment showed that the resident needed assistance with, ambulation, bathing, dressing, self-care ( ), toileting and transferring and could eat independently.

Class II

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on record review and interview the facility failed to complete an elopement assessment after a determination was made that the resident was at risk for elopement for 1 out of 6 sample residents (Resident #2). Also the assisted living facility failed to follow its own resident elopement policies and procedures. The facility also failed to conduct elopement drills twice a year.

The Findings included:

1) On at 12:00 PM resident #2 eloped from the facility for over a week and was found 27 miles away from the facility, in another county.

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A review of the hospital records for Resident #2 showed grossly , illogical and judgment severely .
A review of the facility's record for resident #2 revealed that the resident was diagnosed with; a life threatening illness . Or actual elopement will be documented resident's file and copies of the 1-day and 15-days adverse incident report will be on file.

On at 07:03 AM the Administrator stated that the resident eloped on again on . She stated "We just assumed that she was at the store because she wanted to go to buy cigarettes . When she came from the program, the driver dropped her off in front of the facility and the resident just walked away."

A review of Resident #2's record health assessment, (AHCA Form1823) showed, diagnoses of: , medication noncompliance. Elopement risk was marked NO, Activities of Daily Living (ADL) were all marked independent, except self-care; which the resident needed assistance with. There was no date on the health assessment. Further review of Resident #3's record revealed that no copy of her identification card was on file, and there was no documentation about her elopements.

On at 9:07 AM during an interview, Resident #3 stated, "I do not remember exactly how long I have been living in this place." The resident was very and was unable to be interviewed, even with the assistance of a Creole interpreter. The resident knew her name, but did not know the facility's address or telephone number. The resident stated that she had no identification card. Observation showed that the resident was not wearing any identification .

Record review revealed that no incident report was filed for either elopement.

2) A review of the resident health assessment for other facility residents revealed that 6 out of 6 resident (#1, 2, 3, 4, 5, 6) residents had diagnoses of or other conditions causing .
Diagnoses stated:
Resident#1; , with behavioral disturbance, , .
Resident #3; with behavioral disturbance, ,
Resident #4; Hx of , Batavia, ,
Resident #5; ,
Resident #6; Essential , major with aggressive symptoms and agitation, nonspecific , .

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A review of all records for residents living in the facility revealed that none of them were assessed for elopement risk; even the four residents had been diagnosed with or mental issues that cause or , , (#1,3,4 and 6).

3) A review of wandering and elopement policy and procedures showed that the facility conducted a minimum of two resident elopement prevention and response drill per year, as required by rules and statute. Further review showed that there was no documentation that two drills had been conducted. Two elopement drills were observed on , 2016 and , 2017. The policy further stated that all residents assessed at risk for elopement or with history of elopement shall be identified so staff can be alerted to their needs for support and supervision. The document stated that a minimum, the facility shall have photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary.

Class II

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review and interview the facility failed to properly sign the medication observation record (MOR) for 1 out of 6 sampled residents (Resident # 2).

Findings included:

A review of the medication record for Resident #2 showed that on several days, medications were not signed as given.

On at 8:55 am, the Administrator stated that Resident #2 refused to take the medication and that is the reason why she had spoken to to the care provider to see what action or steps they needed to take.

On at 9:07 AM in an interview with Resident #2, she stated; I do not remember exactly how long I have been living in this place. This resident sounded very and was unable to be interviewed, even with the assistance of an interpreter speaking the resident's first language of Creole. The resident knew her name, but did not know the facility's address or telephone number.

Class III

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

Based on observations, record review, and interview the assisted living facility failed to dispose of

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medications that had expired for two out of six (#2 and #6) residents and for a resident who had been discharged already.

Findings include:

On at 6:20 AM during a tour of the facility, observed expired medications in a plastic bag in the closet where all ofthe other medications was kept:

Resident #2, Metroprolol 25mg
Resident #6, Tenazepam 30mg, 10mg
Discharge resident date unknown, 100mg, , 81mc, B 100mg

On at 9:00 am, the Administrator stated that she was going to disposed this medication very soon.

Class III

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

Based on observation, record review, and interview, the facility failed to have evidence of a negative examination documented on an annual basis for 4 out of 4 sampled staff (A, B, C, D).

Findings included:

Observation on at 6:05 AM found Staff B and D were in the facility assisting the residents with activities of daily living and preparing food for them.

A review of Staff A,E, B, and D's personnel records showed that there was no documentation of annual negative examination on file.

On at 10:00 am, the Administrator stated that she thought all the files were up to date and she did not know what happened with these documents.

Class III

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

Based on observation, record review and interview, the facility failed to provide documentation that three of four sampled employees (Staff A, B, C) had received Elopement training.

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Findings included:

On at 11:15 AM during record reviewed was revealed that files for staff A, (hired date), staff B, (hired date) contained no documentation of the elopement training, and staff C, (hired on), had the training on file but it was not signed.

On at 11:30 AM, the Administrator stated she thought that all the trainings were up to date and in the files of all the staff.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on observation, record review, and interview, the facility failed toprovide documentation that one out of fou r(Staff A) sampled staff to have the continuous 2/hours training for assistance with self-administration of medication.

Findings included:

On at 11:15 AM, staff A confirmed that her responsibilities included assisting residents with self-administration of medication. Record review revealed that Staff A (hired date), had received the initial 4/hour medication training, but was missing the 2/hours update/continuing education training.

On at 11:30 AM the Administrator stated that she had checked Staff A's file before and had found all the trainings were up to date, and now she did not know what happened that this specific training was missing.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview, the facility failed to maintain an accurate admission and discharge log.

Findings:

During a tour of the facility on at 6:00 AM, observed that the facility and its sister facility are

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operated in one continuous building, as one house. Throughout the day on , observed that residents from both sides of the home ate meals together at a dining table, were assisted by the same staff, and had medications stored in one common medication cabinet.

Record review showed that there was one admission and discharge log, containing all residents from either side of the facility, although each side of the facility had its own state license number. There was no documentation of a separate admission and discharge log for each separately licensed facility.

On at 12:30 PM, the Administrator/Owner stated that it was too expensive to merge the facilities because this merge would require walls and one of the duplex's kitchens to be removed. To avoid the expense, she had obtained two separate licenses, one for each side of the duplex, but operated the site as one contiguous facility. She stated that this was why there was only one admission and discharge log, containing residents from both houses.

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 complete and submit adverse incident reports.

Findings included:

Record review showed that On at 12:00 PM Resident #2 eloped from the facility for over a week and was found 27 miles away from the facility.

On at 1:11 PM a phone interview was conducted with the Hospital risk manager, who stated that Resident #2 was found by police at a bus stop in Pompano Beach. She was disoriented and and was taken to a hospital in Broward under .

On at 12:00 PM during an interview with the Administrator she stated that she did not do an incident report with the agency but she called the police for Resident #2's elopement.

On at approximately 2:00 PM, Resident#1's medical providers stated that on , Resident #1 forward on her face while sitting on the couch at the facility. The resident received an eye laceration and was still hospitalized at the time of the interview.

A review of the facility's records showed that there was no documentation of the resident's or hospitalization on .

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A review of the Agency for Health Care Administration's incident report database showed that no incident report was filed for either occurrence.

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Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c) FS

Based on record review and interview the facility failed to have signed Attestations of Compliance with Background Screening for three out of four sampled staff (B, C, and D).

Findings included:

A review of the personnel files of Staff B, C and D revealed that there was no Attestations of Compliance with Background Screening in any of them.

On at 12:00 PM the Administrator stated that she would place the Attestations of Compliance with Background Screening in each staff personnel record.

Class III