STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953342	**06/05/2017**
NAME OF PROVIDER OR SUPPLIER **PROFESSIONAL HOME CARE III, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **447 EAST 26 STREET HIALEAH, FL 33013**	

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

0000 - Initial Comments

A Complaint (CCR #2017004936) survey was conducted on , 2017. Professional Home Care III with limited mental health and limited nursing services components and license #94 had the following deficiencies identified at the time of the survey:

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

Based on record review and interview, the Assisted Living Facility failed to offer personal supervision as appropriate to meet the residents needs for one (#3) out of three sampled residents.

Findings included:

Review of facility's record revealed that Resident #3 had an incident on . Staff Member G was on duty the day of incident. Description of the incident revealed, "Resident #3 tried to some gauze loose there and by accident the gauze completely. Staff Member G put water on the area and was able to turn off the fire only his leg was affected. Staff Member G called rescue and they arrived quick. Police also came to check the ALF (Assisted Living Facility). Resident #3 transferred to the Hospital."

In phone interview on at 2:53 PM Staff G revealed that she was working the day of the incident when Resident #3 his dressing. It happened around 6:30 AM and she was the only staff on duty at that moment for a licensed capacity of 26. She was in the kitchen when she hear the resident was screaming; at that time her coworker (Staff H) was arriving and helped.

In phone an interview on at 2:58 PM Staff H stated, "I arrived when everything already happened."

Observations found on at 9:40 AM to 10:00 AM that the facility's staffing schedule was not followed.

Review staff schedule showed on , 2017 for Monday Staff Member A worked from 9 AM to 12 PM, the Staff Member B worked from 9 AM- 5 PM, Staff Member C worked from 6 AM to 3 PM, Staff Member D worked from 8 AM to 5 PM, Staff Member G worked from 6 PM- 9 PM, Staff Member E worked from 9 PM to 6 AM, Staff Member F worked from 3 PM to 9 PM, Staff Member H worked from 6 AM to 2 PM, and Staff Member worked from 6 AM to 10 AM.

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Class III

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

Based on observation and record review,the Assisted Living Facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern.

Findings included:

Observation on at 9:40 AM revealed that Staff Members D, C, H and I were on duty.

Observation on at 9:57 AM revealed that Staff Member A arrived.

Observation on at 10:01 AM revealed that Staff Member B arrived.

Review staff schedule showed on , 2017 for Monday Staff Member A worked from 9 AM to 12 PM, the Staff Member B worked from 9 AM- 5 PM, Staff Member C worked from 6 AM to 3 PM, Staff Member D worked from 8 AM to 5 PM, Staff Member G worked from 6 PM- 9 PM, Staff Member E worked from 9 PM to 6 AM, Staff Member F worked from 3 PM to 9 PM, Staff Member H worked from 6 AM to 2 PM, and Staff Member worked from 6 AM to 10 AM.

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 Assisted Living Facility failed to submit the incident report within one business day after the incident and within 15 days of the incident to AHCA for one (Resident #3) out of three sampled residents, when resident condition required them to be transported to a unit providing more acute care due to the incident, rather than the resident's condition before the incident.

Findings included:

Review of facility's record revealed that Resident #3 had an incident on . Staff Member G was on duty the day of incident. Description of the incident revealed, "Resident #3 tried to some gauze loose there and by accident the gauze completely. Staff Member G put water on the area and was able to turn off the fire only his leg was affected. Staff Member G called rescue and they arrived quick. Police also came to check the ALF (Assisted Living Facility). Resident #3 transferred to the Hospital."

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An interview on . . . . . at 1:53 PM the Staff Member A revealed that she did not recall if the adverse incident was completed.

Class III