STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963775	**06/12/2017**
NAME OF PROVIDER OR SUPPLIER **ADAM HOME # 2 INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1045 WEST 2 AVENUE** **HIALEAH, FL 33010**	

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

0000 - Initial Comments

A standard biennial survey was conducted from , 2017 through , 2017. Adam Home #2 Inc with limited mental and limited nursing services components and license # 7196 had the following deficiencies identified at the time of the survey:

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation and interview, the Assisted Living Facility's staff member failed to respect resident's dignity for one of 10 sampled residents (Resident #4).

Findings included

Observation on at 7:11 AM revealed that # 's door was opened and Resident #4 sat naked on the toilet. # 's door opened to a common area occupied by other residents.

On at 7:11 AM Staff C acknowledged she left the door open.

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation, record review and interview, the Assisted Living Facility's staff failed to follow the procedures outlined by the state while providing assistance with self-administration of medication to one of ten sampled residents (Resident #5) .

Findings included:

Observation on at 7:05 AM revealed that while Resident #5 was interviewed, Staff Member C arrived from outside the dining area with gloves on, went to the kitchen and gave him a cup with pills, a cup of coffee with milk, Cuban coffee and two slices of bread with butter. Staff Member C did not change her gloves and did not wash her hands or use hand sanitizer. Resident #5 took the 9 pills out of the cup and put them in his mouth one by one and. Staff Member C did not take pills out of the container of the medicines in front of the resident or read the medicines' names.

On at 7:07 AM Staff C stated, "I was helping a resident."

On at 7:08 AM Resident #5 stated, "They always give them to me as today."

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Review of Resident #5's Medication Observation Records (MORs) revealed that medicines were: 10 mg tablet, 40 mg tablet, 20 mg tablet, 20 mg capsule DR, CL 10 mg MEQ tablet, 81 mg tablet, Fumar 200 mg tablet, Sod 500 mg tablet, and 0.5 mg tablet.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation, interview and record review, the Assisted Living Facility failed to note substitutions before or when the meal is served.

Findings included:

Observation on at 7:05 AM revealed that while Resident #5 was interviewed, Staff Member C arrived from outside the dining area with gloves on, went to the kitchen and gave him a cup with pills inside, a coffee with milk, Cuban coffee and two slices of bread with butter.

On at 7:08 AM the Resident #5 stated, "Yes, my breakfast usually is coffee with milk and bread with butter."

Review of menu revealed that breakfast for was assorted juices (4 oz.), dry cereal (3/4 cup) or hot cereal (1/2 cup), bread (1 slice), margarine (1 t) and milk (8 oz.). No substitutions were documented.

Lunch observation on at 12:04 PM revealed that lunch was soup, brown rice, ground beef in with tomato, potato and cocktail.

Review of menu on at 12:05 PM showed that lunch was: soup of day (8 oz.), lean cuts (3 oz.) on bread (2 slices), lettuce and tomato (1 cup), and pudding (1/2 cup).

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 an adverse incident report within one business day after an incident and within 15 days of the incident to AHCA for one (Resident #10) out of 10 sampled residents. Resident #10 after being hit by a car and ejected from his bike.

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Findings included:

An interview on at 7:55 AM Staff A revealed that Resident #10 went out in his bike that day after lunch and did not return. He was hit by a car near the facility. From the accident Resident #10 was transported to the hospital and days later in the hospital. Administrator looked at resident's record and stated, "It happened on and he on ."

On at 8 AM, Staff A revealed that facility has not completed the incident report because they did not think that they had to do it since the happened outside the facility.

Review of hospital record for Resident #10 revealed that Resident #10 was at the Emergency Department in the hospital on at 10:55 AM and chief complaint of . The injury description showed that Resident #10 was struck after being ejected from the bike without helmet; he had superficial in the face, chest, back and extremities and abdomen distended, also pupils were unequal with dilated left at the time of arrival. CT showed , bone with (the space between two of the that surround the) and (surface of the skull) , multiple pelvic . Resident #10 had an emergency frontoparietal , (head surgery) for of massive , hematoma and , . Resident #10 at the hospital from / , failure.

Class III

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Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on record review and interview,the Assisted Living Facility failed to ensure that one out of eight sampled Staff Members had an eligible Level II Background Screening result prior to providing care to residents (Staff Member E).

Findings included:

Review of Staff E's record revealed that documentation of the last eligible Level II background screening was on . . . .

Review of Background Screening Clearinghouse database revealed that background screening for Staff Member E showed "A New Screening is Required"

On at 10:46 AM the Administrator revealed that Staff E had been out of the country, and she just went that day (. . .) to have her fingerprints done.

Unclassified.