STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968864	**06/21/2017**
NAME OF PROVIDER OR SUPPLIER **AMAZING WONDERS**	STREET ADDRESS, CITY, STATE, ZIP CODE **2323 NW 85 ST MIAMI, FL 33147**	

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

0000 - Initial Comments

A Complaint (#2017003927) survey was conducted from to . Amazing Wonders license # 12756 had the following deficiencies found during survey:

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure that 2 of 6 sampled residents met the admission criteria (Residents #1 and #2). Resident #1 was non-ambulatory, could not use his hands because his extremities were contracted beyond use, and required total care on admission to the ALF. Resident #2 needed 24 hour , care. The facility also failed to ensure a comprehensive Health Assessment was properly completed for 3 out of 6 sampled residents (#2, #4 and #5) within 60 days prior to or 30 days after admission to the facility.

The findings included:

Upon arrival to the facility on at 11:30 A.M., Staff B was observed caring for a census of four residents. During the tour Staff B reported, # was occupied by Resident #1, who had , . # was occupied by Resident #2, who had eloped from the facility. Resident #4, who Staff B stated did not live at the facility, was observed asleep in bed.

1) On at 11:50 am, it was observed there was no resident record onsite at the facility for Resident #1. The facility did not have an admission and discharge log onsite. There was no documentation on available to indicate Resident #1 had lived at the facility.

On at 11:47 am, Staff B stated regarding Resident #1, " I do not have his file because [another state agency] took it with them. They have a lot of paper, all his papers, with them."

A review of the progress notes from another state agency (received from the facility's legal representative via email days after the inspection) showed that Resident #1, , was admitted from a group home for persons with severe sometime in 2016 or of 2016. The resident was described as "in need of total care services. He is not able to bathe himself. He cannot walk without assistance. He has a walker but is unstable. He is very aggressive and to the staff members. He constantly throws his diapers off either wet or dry. He likes to be without clothes. He verbally curses the staff upon helping him. He is assisted with all of his meals. The food must be soft for him to eat." A review of records from a 2016 hospitalization showed the resident had two , at the root of the helices , (ear). On the right, it measured 0.7x0.3 cm (centimeters). On the left it measured 3x0.7cm. The resident also had a large sacral (a in

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the area of the sacrum, the wedge shaped at the end of the spine), with measurements not stated in the record. The resident was also diagnosed with (defined as difficulty swallowing), (defined as an of the system to include the kidney, or), unspecified (defined as a mental characterized by a disconnection from reality), movement (defined as drug side effects for persons who receive medications), (defined as a sudden surge of electrical activity in the possibly causing or a change in behavior for a short time), (defined as a condition in which the doesn't produce enough hormone, (defined as a condition where the force of against the wall is too high), and (defined as high levels of fat particles/lipids in the).

A review of the facility's record for Resident #1 showed that there was no documentation of an admission date, a contract between the resident and the facility, or any other move-in documents, including a power of attorney. Further review of the notes from another state agency showed, the resident's brother was his legal guardian. There was no documentation in the file that the guardian had given consent for Resident #1 to move to the ALF. Further review of the resident record showed, there was no documentation that the resident was receiving home health services for his .

A review of the staff records showed, there was no documentation that the administrator or any staff person was a licensed medical professional, trained to care for Resident #1's sacral or the two other .

A review of hospital records showed, Resident #1 on , 2017. The resident had been receiving medication administration and nutrition through a tube (Endoscopic , a tube in the stomach to provide a means of feeding for people who have /difficulty swallowing) by unlicensed ALF staff for three days before being hospitalized with (a potentially life-threatening).

2) A review of Resident #2's health assessment provided by the facility on revealed the document was undated. The assessment showed the resident needed 24 hour care, and needed supervision with all activities of daily living. The diagnoses included: to lower extremities (defined a skin), , (defined as a that affects a persons ability to think, feel and behave clearly), Chronic Use and smoking and an elopement risk. The assessment did not indicate if the resident needed assistance with medication, or what kind of assistance (self-administration or medication administration). The Administrator provided a second health assessment on . This assessment was dated and indicated the resident was independent.

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On at 11:47 am, Staff B reported, Resident #2 was living at the facility for a month or two, and he walked away. He further stated, "Resident #2 was admitted on , 2017, and left. I believe that in he left, and the police brought him back to the house. He was here in the month of , until , 2017 and he walked away again." Staff B further stated, "The resident does not have a MOR (medication observation record) for , 2017 because he ran away. He did not have SSI (social security income) or insurance, so there was no way to get his medication."

3) On at 11:35 am, Staff B reported, # was a private Resident #1 lived before he , and that now this occupied by Resident #4. He further stated, "I'm fixing her bed now, that's why the bed does not have linen. She is not an ALF resident, she is here temporarily for a few days because the other house where she lives has a tent." Resident # 4 was observed leaving the going to sit in the living . The resident was not able to be interviewed.

A review of the facility records showed there was no documentation that Resident #4 was living in the home and sleeping in # . A review of the resident records showed there was no records for Resident #4. An observation of the medication cabinet revealed Resident #4's medications were present. A review of the Medication Observation Records (MOR) showed there was an MOR for Resident #4, for the month of , 2017. The resident was prescribed , 500 mg (milligrams), Benzetropine 2mg, , 200 mg, , 1 mg and , 10 mg ordered at 7:00 A.M., 3:00 PM and 11:00 PM. According to the Mayo Clinic, , is described as an anticonvulsant used to treat the phase of , or . , is described as a phenothiazine; a medication used to treat serious mental and emotional , , is used to treat , , is used to treat high , , chest pain or irregular beat. Benzetropine used to treat and side effects of other drugs ,

On at 12:16 pm, Staff B reported, Resident #4 was independent, but needed 24 hour supervision and assistance. He further stated, "I do assist her with medication and all Activities of Daily Living (ADL).

On at 1:04 pm, the Administrator stated, "Resident #4 does not belong to this house. She moved from [another state agency's] group home to the ALF. She is a free client. We are helping her without any payment." At 1:09 pm, the Administrator stated, "yesterday we went to the hospital and they did not refill her medications. They are going to give her a shot."

A review of a document found in the facility not connected to a resident record showed the facility acted

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as payee for Resident #4's social security benefit payments.

4) On at 1:10 pm, Staff B and the Administrator reported Resident #5 was independent.

A review of Resident #5' record revealed, an Assisted Living Facility (ALF) admission and financial Agreement dated for the monthly amount of $680.00 and a waiver of $1200.00, resident weight sheet, assistance with medication, and a signed informed consent dated on . There was no documentation of a face to face health assessment (AHCA 1823) Agency for Health Care Administration done within 60 days prior to the admission or 30 days after the admission date to indicate diagnoses and what kind of assistance the resident needed, including with her medications. Further review of the record showed documents from an earlier state hospitalization which identified the resident as being at high risk of elopement, displaying dangerous behaviors to other residents, and needing assistance with medication.

During an interview on at 3:40 PM Resident #5 stated, "I have my medication with me." The resident took her purse from the floor and showed two bottles of prescribed medication.

Class I

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

Based on interview and record review, the facility failed to determine ongoing appropriateness for continued residency for 2 of 6 sampled residents (Residents #1, and #2). This was evidenced by the facility's failure to meet the increased care needs for Resident #1 who experienced a decline in health with resulting in a endoscopic ( ) tube being placed. Resident #2 eloped from the facility three times, with facility staff making no interventions between elopements.

The findings included:

1) A review of records from another state agency found that Resident #1 was admitted to the Assisted Living Facility (ALF) sometime in 2016 or of 2016. The resident needed total care upon admission to the ALF. The resident's extremities were contracted beyond use. The resident had diagnoses to II, and a on the sacrum and the great toe of the right foot. The residents hospital records did not identify the stage of these wounds, but described the sacral as 'very large.'

A review of facility records revealed, there were no records onsite for Resident #1. The facility's legal

representative emailed a copy of the record to the Agency for Health Care Administration (AHCA), and the original record was later obtained from another state agency. After the records were obtained, it was revealed, there was no documentation by the facility that the resident had been hospitalized several times.

On at 3:56 pm, Resident #1's caseworker from another state agency reported, "He went to the hospital several times, for example on , our agency received an incident report that the resident was transferred to an Emergency . On , he was transferred to a hospital and on he was discharged to the ALF. I went to the ALF to visit him. On my client went to the Hospital, on he was discharged back to the ALF.

A review of the hospital records revealed, Resident #1 was hospitalized at least three more times before his :

1. A , 2017 hospital record revealed, Resident #1 was admitted for a decline in function. The resident had with ESBL (Extended Spectrum Lactamases-an produced by) , , , II, and . Further review shows that the resident developed an Ileus. The resident had two , , at the root of the helices . On the right, it measured 0.7x0.3 cm (centimeters). On the left it measured 3x0.7cm. The resident also had a large sacral , with measurements not documented in the record. The resident was in the and was eventually transferred to another hospital for continued treatment prior to returning to the ALF.

2. A , 2017 hospital record revealed, Resident #1 was hospitalized until , 2017 for functional decline and . The resident had a decreased appetite, was unable to follow commands and required total assistance with all bed mobility. The resident was unable to sit, stand or transfer. A (Endoscopic) Tube was installed to facilitate the resident's receipt of nutrition directly into his stomach due to difficulties swallowing. According to hospital records at discharge on , the resident needed placement at a skilled nursing facility and was being discharged via stretcher. Instead of being sent to a nursing home, Resident #1 was returned to the assisted living facility. The resident needed continuous tube feedings at 65cc (cubic centimeters) per hour, with clear water flushes at 300 cc every 4 hours.

During interview on at 2:01 pm, the Administrator reported Resident #1 was discharged from the hospital with a in place, and that a nurse from the hospital came to the facility on the evening of to remove the and to teach the staff how to administer the resident's

medication and nutrition through the tube. She reported, the facility staff fed the resident through the tube four or five times per day. The Administrator reported, Staff B and Staff C were administering medication and nutrition to Resident # 1 through the tube on , , and until he returned to the hospital on . The administrator confirmed, neither Staff B nor Staff C was a nurse or other licensed medical professional. The Administrator reported, she did not know that the facility staff could not administer medications, or food through the tube.

The hospital record documented Resident #1 needed continuous tube feedings at 65cc per hour, with clear water flushes at 300 cc every 4 hours and the following medications were prescribed for the resident: , baby, 81 mg (milligrams) by mouth; Benzetropine .5 mg by mouth twice daily; 10 mg as needed; 20 mg oral; Acidophilus Three times a day with meals; Levetiracitam 500 mg by mouth every 12 hours; 0.125 mg by tube daily; 300 ml (milliliters) by mouth once only, if constipated within 48 hours; Polyethelene Glycote 3350, 17 gm(grams), oral, once daily; 100mg, oral HS(hour of sleep); 7.5 mg, oral, PRN(as needed); Jevity 1.5 mg, tube feeding, with goal of 65cc per hour. The facility did not have any documentation the resident was receiving home health agency care from a qualified health professionals to administer the tube feeding for nutrition and medications through the tube.

During interview on at 2:05 PM the Administrator reported, Resident #1 was able to swallow. The administrator showed a photo in her personal cellular phone that showed Resident #1 drinking from a cup. She stated, "the hospital always said he had trouble swallowing, but I know my residents. He was constantly asking for something to drink or eat, so we gave it to him. When asked how she thought these drinks or meals affected the Residents' diagnosis of , she stated, the hospitals could never agree on whether he really had the condition or not. She further reported, once the tube was inserted, they no longer gave Resident #1 food or drink by mouth.

3. A review of the hospital records showed Resident #1 was returned to the hospital on , because he was severely constipated for four days, and was . His hospital diagnoses included, Ileus (a disruption of the normal action of the intestines, where food or waste no longer progresses through the intestines); Small Bowel Obstruction, Acute Kidney Injury and Chronic Kidney - secondary to , severe protein calorie likely from poor oral intake and lower extremity , likely secondary to not specified, mental , , and . The resident on , 2017.

2) During an interview on at 11:47 AM Staff B reported, Resident #2 was living here at the house for a month or two and he walked away. Staff B stated, "I don't know where he is at this moment,

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we filed a police report. Staff B revealed, Resident #2 was admitted on , 2017 and he left. I believe in 2017, he left and the police brought him back to the house. He was here in , 2017 until , 2017 at 6:30 P.M., then he walked away again. Staff B reported, this resident did not have a medication observation record (MOR) for the month of , 2017 because he did not have medication. The resident had to go back to the hospital for an appointment to refill his medication. Staff B reported, I made the appointment for , 2017 and he ran away on ." Staff B further stated, Resident #2 was without medication from until the when he ran away." Staff B reported, the resident did not have insurance or income, and there was no way to get his medications.

A review of Resident #2's health assessment provided by the facility on revealed the document was undated. The assessment showed the resident needed 24 hour , care, and needed supervision with all activities of daily living. The diagnoses included: to lower extremities (defined a skin), , (defined as a that affects a persons ability to think, feel and behave clearly), Chronic Use, smoking and an elopement risk. The assessment did not indicate if the resident needed assistance with medication, or what kind of assistance (self-administration or medication administration). The Administrator provided a second health assessment on . This assessment was dated and indicated the resident was independent.

The resident's record did not have documentation of the three elopements except for the police report number for a missing person's report for two of the episodes.

A review of the facility's elopement policy showed, "Each individual will be assessed for risk of elopement during the referral and admissions process. Assessment may also occur after admission due to demonstration of elopement behavior." The policy further documented, Individuals identified to be at risk will receive identification on their person or possibly their wheelchair stating the following: individual's name, name of facility, address, phone numbers. Individuals identified to be at risk will have a photo identification for use by all agency personnel, other agencies as necessary and law enforcement. Photo identification will be obtained upon admission and/or within 10 calendar days. A review of the resident records showed, there was no documentation of an elopement assessment for any resident, and no photos of residents were in the files.

During interview on At 1:23 PM the Administrator reported, Resident #2 was found wandering the street, and did not know how to get back to the facility, after his first elopement. The police took him to the hospital. The administrator reported, when Resident #2 ran away in , 2017, the police found him in the Florida Keys, and put him in jail on an old warrant. She further stated, "the person who referred Resident #2 from the hospital told me that he is a problem. I spoke with Resident #2, he showed me his

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arm and told me that he is a drug addict. He stated, he robbed things to get money to buy drugs. I did nothing to prevent the elopement, because they can walk away if they want. The administrator reported, I do not have photos on record, and I do not have identification that residents wear when they leave the facility. "

During the survey from through the Administrator reported, she did not have any knowledge about the ALF regulations and how these problems can be corrected.

Class I

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on record review and interview, the Assisted Living Facility failed to ensure that a licensed person administered medication to two out four sampled residents (residents #1 and #3).

The findings included:

1) During interview on at 8:48 AM Caregiver C stated, "Resident #3 has a that doesn't allow cooperating in anything and I have to give the medications to her in the mouth. She doesn't eat or drink by herself." This facility failed to follow ALF regulations for assistance with medications.

2) Record review revealed, Resident #1 was admitted approximately in of 2016, the resident needed total care when he was admitted to the assisted living facility (ALF), the resident's extremities were contracted beyond use.

A , 2017 hospital record revealed, Resident #1 was hospitalized until , 2017 for functional decline and . The resident had a decreased appetite, was unable to follow commands and required total assistance with all bed mobility. The resident was unable to sit, stand or transfer. A (Endoscopic ,) Tube was installed to facilitate the resident's receipt of nutrition directly into his stomach due to difficulties swallowing. According to hospital records at discharge on , the resident needed placement at a skilled nursing facility and was being discharged via stretcher. Instead of being sent to a nursing home, Resident #1 was returned to the assisted living facility. The resident needed continuous tube feedings at 65cc (cubic centimeters) per hour, with clear water flushes at 300 cc every 4 hours.

During interview on at 2:01 pm, the Administrator reported Resident #1 was discharged from the hospital with a in place, and that a nurse from the hospital came to the facility on the evening of

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to remove the and to teach the staff how to administer the resident's medication and nutrition through the tube. She reported, the facility staff fed the resident through the tube four or five times per day. The Administrator reported, Staff B and Staff C were administering medication and nutrition to Resident # 1 through the tube on , , and until he returned to the hospital on . The administrator confirmed, neither Staff B nor Staff C was a nurse or other licensed medical professional. The Administrator reported, she did not know that the facility staff could not administer medications, or food through the tube.

The hospital record documented Resident #1 needed continuous tube feedings at 65cc per hour, with clear water flushes at 300 cc every 4 hours and the following medications were prescribed for the resident: , , baby, 81 mg (milligrams) by mouth; Benzetropine .5 mg by mouth twice daily; , 10 mg , as needed; 20 mg oral; Acidophilus Three times a day with meals; Levetiracitam 500 mg by mouth every 12 hours; , 0.125 mg by tube daily; 300 ml (milliliters) by mouth once only, if constipated within 48 hours; Polyethelene Glycote 3350, 17 gm(grams), oral, once daily; , 100mg, oral HS(hour of sleep); , 7.5 mg, oral, PRN(as needed); Jevity 1.5 mg, tube feeding, with goal of 65cc per hour. The facility did not have any documentation the resident was receiving home health agency care from a qualified health professionals to administer the tube feeding for nutrition and medications through the tube.

A review of the hospital records showed Resident #1 was returned to the hospital on , because he was severely constipated for four days, and was . His hospital diagnoses included, Ileus (a disruption of the normal action of the intestines, where food or waste no longer progresses through the intestines); Small Bowel Obstruction, Acute Kidney Injury and Chronic Kidney , , secondary to , severe protein calorie likely from poor oral intake and lower extremity , likely secondary to , , , , , , , , , , , not specified, mental , , and . The resident on , , 2017.

Class II

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

Based on observations, record reviews, and interviews, the Administrator failed to maintain the general oversight of the daily operation of the Assisted Living Facility, which had a census of five. The Administrator also failed to ensure the appropriateness of admission and continued residency for at least three of seven residents (Residents#1,#2, and #4) and failed to ensure that qualified staff were providing adequate care and services to the residents. The Administrator failed to ensure that resident records

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were completed for 6 out of 7 (#1, #2, #3, #4, #5,and 6) sampled residents. The Administrator failed to ensure that residents received medications timely, and failed to maintain updated medication observation records (MOR). The Administrator failed to have completed records for staff A, B and C sampled, that included an employment application, an eligible level 2 background screening and the required in-services to care for a census five residents. The Administrator failed to maintain an admission and discharge log, progress notes, or elopement drill records for 7 out of 7 residents (#1, #2, #3, #4, #5, #6 and #7) . The Administrator failed to file adverse incident reports with the Agency for Health Care Administration (AHCA) after Resident #2 eloped three times from the facility and was hospitalized.

The findings included:

During a survey from thought , the Administrator stated that she did not have any knowledge about assisted Living Facility (ALF) regulations and how these problems can be corrected.

1) Resident Records

During a tour of the facility on at 11:30 am, Staff B revealed that # was occupied by Resident #1 that , and # 's empty bed was occupied by Resident #2 that eloped from the facility. A review of resident records showed that there were no records for Resident #1. There were no progress notes or incident reports regarding Resident #2's elopement.

a. A review of hospital records and records from another state agency showed that Resident #1 was admitted approximately in of 2016, the resident needed total care when he was admitted to the assisted living facility (ALF), the resident's extremities were contracted beyond use. The resident had diagnoses to include , II, a on the sacrum and right foot great toe. The hospital records did not identify the stage of these wounds, but described the sacral as 'very large.'
Resident #1 was discharged from the hospital on by stretcher, to the ALF even though skilled nursing was identified by the physician as being the needed level of care. The diagnoses on the hospital admission a few days before the residents included, Ileus (a disruption of the normal action of the intestine, where food and waste no longer progress through the intestines); Bowel Obstruction, Acute Kidney Injury on Chronic Kidney , -secondary to , severe protein calorie likely from poor oral intake and lower extremity , likely secondary to , not specified, mental , , and . Between and , the resident was hospitalized and a (Endoscopic ,) tube was inserted and a facility caretaker, who wasn't a

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licensed professional administered his medication and food through the tube. Flushes of the tube were prescribed 3 times daily. During interview with the ALF administrator, it did not appear she had knowledge that unlicensed staff couldn't perform this type of care. Resident #1 was admitted to the hospital on with severe and other diagnoses listed above. The resident on , 2017.

On at 2:01 PM, the Administrator reported Staff B and staff C were feeding and administering Resident #1 medication and food through the tube. Staff B acknowledged, he did not have a professional license authorizing him to administer medication and tube feeding through the tube.

b. During an interview on at 11:47 A.M. Staff B reported, Resident #2 was living at the facility for a month or two and he walked away. He reported, Resident #2 was admitted on , 2017 and he left. Staff B reported, I believe in 2017 he left and the police brought him back to the house. He was here in , 2017 until , 2017 then he walked away again."

Resident #2's record revealed, the health assessment listed him as needing 24 hour care, and needing supervision with all activities of daily living. Resident #2's diagnoses included, lower extremities, , Chronic Use, smoking and an elopement risk. The health assessment did not have indication if the individual needs assistance with the medication and what kind of assistance (self-administration or medication administration). The resident was identified as an elopement risk. The record did not have documentation of the events surrounding the times when the resident had left the facility. The facility only had the police report number.

On at 1:28 P.M. on , the Administrator stated, "I do not have a complete record for Resident #2. He he had a different situation because a hospital sent him here."

Record review of the facility's elopement/missing person policy and procedures revealed the facility did not follow its own procedures regarding wandering behavior. Staff did not demonstrate an understanding and competency of the policy and procedures. There was no documentation that residents were assessed for their risk of elopement during the referral and admissions process. The elopement assessment could occur after admission due to a demonstration of elopement behavior. The residents identified to be at risk did not receive identification on their person that included the following: the individual's name, name of the facility, address, and phone numbers. The residents identified to be at risk did not have a photo identification for use by agency personnel, others agencies as necessary and law enforcement obtained upon admission and/or within 10 calendars days.

On at 3:20 P.M. the Administrator reported no elopement drill was done. She stated, she did

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not file adverse incident report for one day and 15 days with the Agency for Health Care Administration (AHCA). She sent a report to the hospital because he was admitted from there.

Staff B reported this resident did not have a medication observation record (MOR) for the month of , 2017 because he did not have medication. He stated, the resident had to go back to the hospital for an appointment to refill his medication. I made the appointment for , , 2017 and he ran away on , 13th. Staff B reported, Resident #2 was without medication from until when he ran away. Staff B reported, the resident did not have insurance, and there was no way to get his medications.

c. On at 11:45 A.M Staff B reported, Resident #4 occupied # . Resident #4 was called, by the administrator and staff, a free client. The Administrator stated that resident does not belong here, to this house. She stated that the resident was a client that belonged to the other house.

A review of Resident #4's record showed that she did not have a file. A payment from a federal agency showed the controlling interest for the resident was the facility as the payee for Resident #4. The residents medication observation record (MOR) was found for the month of , 2017. The list of medications was included, , 500 mg (milligrams), Benzetropine 2mg, , 200 mg, , 1 mg and , 10 mg ordered at 7:00 A.M., 3:00 P.M. and 11:00 P.M. Bottles of these medication with Resident #4's name on them were found in the facility's locked medication cabinet.

d. A review of Resident #5 who was called an "independent resident", contained an Assisted Living Facility (ALF) admission and financial Agreement dated for the amount of $680.00 and a waiver for $1200.00, a resident weight sheet, an assistance with medication informed consent signed and dated on . There was no face to face health assessment (Agency for Health Care Administration-AHCA 1823) done within 60 days prior to the admission and/or 30 days after the admission to indicate diagnoses and what kind of assistance the resident needed with her medication. The resident record did not contain documentation or progress notes.

On at 12:53 PM, the medications locked inside of the facility's cabinet located in the kitchen were reviewed with the Administrator and Staff B to identify the reason medication were still at the facility. OTC (over the counter) medications without resident names were observed to include, Fish oil 1200 mg, , 5, C 500 mg, two bottles of Sentry supplement, Qvar 80 mcg(micrograms), Senior Probiotic formulated, Wal-Dryl , Aquaporin advanced , . Resident #1 who , on medications were found in the medication cabinet for the month of , 2017 and included, Carb 450 mg, Levothyroxin 50 mg, 20 mg,

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, 0.5 mg, Levetiraceta 500 mg, , 81 mg and , 25 mg.

e. On at 12:55 PM, the Administrator reported, Resident # 7 had left the facility for a long time. Her medications found in the locked medication cabinet were: 40 mg, cap 4.5 mg, , 10 mg, 10 mg, , 5 mg., over the counter medications and 70 mg.

During an interview on at 12:53 P.M., the Administrator did not have knowledge that OTC medications needed to be labeled with the resident names and couldn't be shared with others residents.

During an interview on at 1:07 P.M. the Administrator reported she did not have knowledge of how to discard medications after resident's left the facility.

f. A review of Resident # 3's medication observation record (MOR) revealed, a list of medications to include, 40 mg, , 300 mg, , , 50 mg, 20-10 mg, , 50 mg, and , medications were not initialed on , and / 2017 by staff and the medication pack had punched open.

g. A review of Resident #6's MOR showed that scheduled at 9:00 A.M. 80 mg was not initialed on at 9:00 A.M. D 3, and 10 mg was not initialed on and at 9:00 A.M. 40 mg, 0.2 eye drop was not initialed by staff. , 0.005 eye drops, , 100 mg, 10 mg and , 100 mg were not initialed on to . On at 11:57 A.M., Staff B acknowledged, the MORs were not initialed for a few days, and he asked for the MOR to sign.

2) Staff Records

A review of the Administrator's personnel record revealed no documentation of First Aid and (,) Training or CORE training identification card. There was no documentation of Food Inservice Training annually. The most recent training on assistance with self-administration of medication training was dated . The last ( ) clearance from a health care provider was dated on .

During an interview on at 2:57 P.M. Staff B reported, he had been working at the facility for 2 years. A review of personnel records revealed, Staff B did not have a complete personnel record which included an employment application, background screening, in-service training documentation for control, ,) training, emergency preparedness, evacuation

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training, incident report training, resident rights training, recognizing/reporting , neglect and , training, First Aid, and self-administration of medication (4 hour) training in assisted Living Facility (ALF). The review also found the level 2 background screening result for Staff B showed "Agency Review Required."

During an interview on at 3:12 P.M., the Administrator stated, "I have staff records in the other house. I will email Staff B and C eligible background screening."

3) Facility Records

Record review revealed that there was no admission and discharge log to identify how many residents had been admitted or discharged from the facility.

Record review showed that while a menu was posted, the items listed were not served and there was no documentation of substitutions.

Record review showed that there was no record of elopement drills having been conducted.

A review of the the staff schedule showed that it did not accurately reflect who was working.

A review of the background screening clearinghouse database showed the facility did not have an updated staff roster. Staff B and C names were not listed.

A review of the adverse incident report database showed that no adverse incident reports were filed about three resident elopements or several resident hospitalizations. Further review showed that no internal records of these incidents were kept at the facility.

Class I

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on interview and record review, the facility failed to file an adverse incident report for 2 of 7 sampled residents (Residents #1 and 2). Resident #1 had multiple serious and extended hospitalizations, and Resident #2 was missing from the facility three times and end up hospitalized.

Findings included:

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1)
On at 3:56 pm, Resident #1's caseworker from another state agency said "He went to the hospital several times, like for example on , our agency received incident report that the resident was transferred to an Emergency . On He was transferred to a Hospital and he was discharge to the ALF. I went to the ALF to visit him. On my client went to the Hospital, on he was discharge back to the ALF.

A review of hospital records showed that Resident #1 was hospitalized at least three more times before his :
-In , 2017 hospital record showed that Resident #1 was admitted to the hospital.
-A , 2017 hospital record showed that Resident #1 was hospitalized until , 2017.
-A review of hospital records showed that Resident #1 was returned to the hospital on . The resident on , 2017.

On at 11:47 am, Staff B stated that Resident #2 was living at the facility for a month or two, and he walked away. He further stated "Resident #2 was admitted on , 2017, and left. I believe that in he left, and the police brought him back to the house. He was here in the month of , until , and he walked away again." Staff B further stated "The resident does not have a MOR for , 2017 because he ran away. He did not have SSI or insurance, so there was no way to get his medication."

During an interview on at 3:20 P.M. the Administrator stated that she did not file 1 day and 15 days incident reports with the agency (AHCA) for Resident #1's multiple hospitalizations and Resident #2 that eloped at least twice from the facility and police officers were called. She stated "I sent a report to a hospital for Resident # 2 because he was admitted from there." The Administrator stated that AHCA had many regulations and she does not want that.

Class III

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Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on record review and interview, the facility failed to maintain documentation of the eligible results of a background screening onsite in the facility's personnel files for 1 of 3 sampled staff (Staff C).

Findings included:

A review of the work schedule posted on the kitchen refrigerator dated . . . to . . . showed: the first and second week of the month from Sunday to Wednesday, Staff B was scheduled 2:00 P.M. to 8:00 P.M. On Thursday, Staff A was scheduled from 8:00 A.M. to 2:00 P.M., and Staff C was scheduled Friday to Saturday from 8:00 A.M. to 6:00 P.M.

A review of personnel records showed that there was no documentation of an eligible Level II background screening found for Staff C. The documentation review revealed the background screening dated documented "Agency Review Required." The Background Screening database was reviewed and documented eligible on . . . .

On . . . at 3:12 p.m. the Administrator stated, "I have staff records in the other house. I will email Staff B and C eligible background screenings."

Unclassified

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on observation, record review, and interview, the Assisted Living Facility failed to register with the Background Screening Clearinghouse and maintain the employment status of all employees on the facility's roster within the clearinghouse.

Findings included:

Observation on 11:30 A.M., revealed Staff B was alone and taking care of four residents activities of daily living (ADL).

On . . . at 2:57 P.M. staff B stated, he has been working at the facility for 2 years.

A review of Staff C's personnel record revealed her hire date was . . . .

A review of the Background Screening Clearinghouse database revealed, the facility's employee roster

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did not include Staff B and C names.

On at 3:57 P.M., the Administrator acknowledged the background screening roster was not updated.

Unclassified

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

Based on observation, interview and record review, the facility failed to obtain an Eligible Level II background screening for 1 of 3 sampled staff who was providing care and services to residents and who had access to residents belongings (Staff B).

Findings included:

Observation on at 11:30 A.M., revealed Staff B was in the facility alone and taking care of four residents activities of daily living (ADL).

On at 2:57 P.M., Staff B stated, he had been working at the facility for 2 years.

Review of the work schedule posted on the kitchen refrigerator dated to showed the followings: the first and second week of the month Sunday to Wednesday Staff B was scheduled from 2:00 P.M. to 8:00 P.M. On Thursday Staff A was scheduled from 8:00 A.M. to 2:00 P.M., and Staff C from Friday to Saturday from 8:00 A.M. to 6:00 P.M.

Record review showed Staff B did not have documentation of an eligible background screening for review. Staff B was not found in the Background Screening Clearinghouse database.

During an interview on at 2:57 P.M. Staff B acknowledged, the background screening eligibility result was not in the record for review. He stated, he had been working at the facility for 2 years and he had the background screening, but it was not in his record.

During an interview on at 3:12 P.M., the Administrator stated, "I have staff records in the other house. I will email Staff B's eligible background screening."

Unclassified