STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967433	**07/19/2017**
NAME OF PROVIDER OR SUPPLIER **M & J QUALITY CARE, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **13231 SW 278 TERRACE** **HOMESTEAD, FL 33032**	

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

0000 - Initial Comments

A mnitoring survey conducted at M & J Quality Care, LLC Assisted Living Facility from and concluded on related to complaint investigation (CCR #2017005617) regarding an undefined facility at 16500 SW 107 Ave, Miami, Florida on . The Assisted Living Facility had deficiencies at the time of the survey.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on observation, interview, and record review, the assisted living facility failed to have a complete health assessment that included whether the individual will require any assistance with the administration of medication for 1 of 8 sampled residents (Resident #4)

Findings include:

A review of Resident #4's health assessment, dated , did not have a box checked whether the resident needed assistance or did not need assistance with self-administration of medications.

In an observation on at 12:20 PM of centrally stored medication, a pill organizer was observed for Resident #4.

In an interview on at 12:25 PM, Staff C stated Resident #4's medications were placed in the pill organizer by Resident #4's daughter. In an interview at this time, Staff C stated that facility staff take Resident #4's medication out of the pill organizer twice daily (morning and night) and then staff place the medication into a little cup, which the staff then hands to Resident #4. Staff C stated that none of the staff at the facility was a licensed nurse.

Class III

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

Based on observation, interview and record review, the assisted living facility failed to honor residents' rights by moving 2 of 8 sampled residents (Resident # 1) and 1 former resident (Resident #6) who required assisted living services and care, to an undefined facility location.

Findings include:

In an interview with Resident #1 on at 3:40 PM, the resident stated that they lived in in the licensed facility and then Staff B moved Resident #1 to another house that was north. Resident #1

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967433	07/19/2017
NAME OF PROVIDER OR SUPPLIER **M & J QUALITY CARE, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **13231 SW 278 TERRACE** **HOMESTEAD, FL 33032**	

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

stated that when she came back to the licensed facility, she went to to live with Resident #2. Resident #1 stated that they did not want to live at the other location and did not want to lose their the licensed location. Resident #1 stated that she was not provided with a 45-day notice to relocate to the undefined facility.

A review of Resident #1's admission package documentation, did not include the facility's policies regarding control, sanitation and universal precautions nor the requirements for coordinating the delivery of services to residents by third party providers.

In an interview with Staff C on at 2:05 PM, they stated that Resident #7 was admitted to the facility on .

A review of the admission and discharge log on , documented that the facility did not list the admission or discharge dates for Residents #6 and 7.

In an interview on at 12:15 PM, Staff B stated that Resident #6 was brought to the undefined facility, every night, for a month.

In an interview with the Administrator on at 3:25 PM, she stated that Resident #6 was moved back and forth from the licensed location and to the undefined facility.

A review of Resident #6's health assessment, dated , documented that Resident #6 had wounds on the sacral and heel regions of the body upon admission to the assisted living facility.

In an interview with Resident #4 on at 3:15 PM, the resident stated that they moved to the licensed facility in 2016. Resident #4 stated that when they moved into the licensed location, Resident #4 was living with Resident #2. Resident #4 stated that Resident #1 was at the licensed location on the first night that Resident #4 lived there and that on the following night, Staff B took Resident #1 to the undefined facility location for 2 nights and subsequently, Resident #4 took Resident #1's . Resident #4 stated that in , 2017, Staff B asked her whether she wanted to see the other location. Resident #4 stated that Staff B has two houses for people to live. Resident #4 stated that she never went to the other location but there were other residents from the licensed location that had gone to the undefined facility.

In an interview with Staff C on at 4:50 PM, she stated that she and Staff B did not live at the undefined facility. Staff C stated that only she and Staff B had keys to the undefined facility.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967433	07/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & J QUALITY CARE, LLC	**13231 SW 278 TERRACE HOMESTEAD, FL 33032**

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

Class III

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

Based on observation, interview, and record review, the assisted living facility put residents at-risk by not having qualified licensed personnel to administer and manage medications for 3 of 8 sampled residents (#3, #4, and #7). Specifically, the facility failed to have a licensed nurse perform the required tasks of glucose monitoring, preparation of medication and using pill organizers for Residents #3, #4, and #7, and instead, had unlicensed staff perform these tasks.

Findings include:

1. In an interview on at 1:15 PM, Staff D stated she sometimes helped Resident #3 with injections. In an interview at this time, Staff D stated that she was not a licensed nurse.

In an interview on at 1:15 PM, Resident #3 stated Staff A and D provide him with , dialed the pen to the correct amount, tell him a good spot on his body to inject, then hand him the pen and he injects the by pressing the button himself.

In a medication observation in Resident #3's at 5:05 PM, Staff D wore gloves and took out an pen from a cloth case. Staff D opened an preparation , and wiped Resident #3's right index finger with the preparation , . Resident #3 stated that his right index finger was . Staff D then used another preparation , on Resident #3's right middle finger. Staff D stuck Resident #3's right index finger and Resident #3 said, "owwww" at this time. A brief argument occurred between Staff D and Resident #3, in which Staff D stated Resident #3 moved his finger at the time of the fingerstick. Staff D restuck the right index finger. Staff D took a glucose testing strip, put it on the index finger and then put the glucose testing strip into the glucometer. The glucometer was unable to provide a reading on the glucose level from this first attempt. Then Staff D squeezed the sides of Resident #3's right index finger and stated that there wasn't enough . Resident #3 said, "Don't squeeze with your nails". Staff D repeated aloud that there was not enough . Another brief argument occurred between Staff D and Resident #3. Staff D put from the right index finger onto the glucose testing strip, and then placed the glucose testing strip into the glucometer. The glucometer was unable to provide a reading on the glucose level from this second attempt. Staff D took a new preparation , and used it to sanitize Resident #3's right ring finger. Staff D stuck Resident #3's right ring finger. Staff D put from the right ring finger onto a glucose testing strip and then placed the glucose testing strip into the glucometer. The glucometer was unable to provide a reading on the glucose level from this third attempt. Staff D repeated aloud that there was not enough . Resident #3 stated that the sticking hurts his fingers. Staff D then stuck Resident #3's right pinkie finger.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967433	07/19/2017
NAME OF PROVIDER OR SUPPLIER **M & J QUALITY CARE, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **13231 SW 278 TERRACE** **HOMESTEAD, FL 33032**	

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

Staff D put from the right pinkie finger onto a glucose testing strip and then placed the glucose testing strip into the glucometer. The glucometer provided a reading on this fourth attempt of 157 mg/dl (milligrams per deciliter). Staff D left Resident #3's go to the kitchen. In the kitchen, Staff D opened a medication cabinet and inside of the medication cabinet, a chart was posted, depicting units of to use for the sliding scale, according to the physician's order. Staff D said that Resident #3 would need 9 units based on the sliding scale posted in the cabinet. Staff D went back into Resident #3's . Staff D sanitized a spot on Resident #3's right lower stomach with an preparation , . Staff D then dialed 9 units in the pen and handed the pen to Resident #3. Resident #3 stated that he could not see the spot on his stomach. Staff D lifted Resident #3's shirt higher and Staff D placed her hand on the Resident's right lower stomach. Resident #3 stated, "Don't squeeze me. It hurts. Just tell me where it goes. Not on a spot". Resident #3 took the pen, put the needle into the right lower stomach and pressed the button down to inject himself. Staff D did not record the glucose levels and units of in a separate log. Staff D did not change gloves from the beginning to the completion of the medication pass.

A review of the facility's medication observation record (MOR) documented that Resident #3 had a medication listed as Comfort EZ Pen needles 5 MM 31 G to use four times a day. There were no entries/markings in the MOR under this medication to document that it was being used four times a day. Additional documentation was observed in the resident file, on handwritten logs that were separate from the MOR. These logs were incomplete MORs as they did not include the name of the resident and any known the resident may have; the name of the resident's health care provider, the health care provider's telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors.

A review of Resident #3's health assessment, which was not dated by the examiner, documented that Resident #3 required nursing services for and injections. The health assessment documented directions for the sliding scale: 0 to 70 - 0 units; 71 to 200 - 0 units; 201 to 250 - 2 units SQ ( ); 251 to 300 - 4 units SQ; 301 to 350 - 6 units SQ; 351 to 400 - 8 units SQ; 401 to 450 - 10 units SW; > 451 - 12 units SQ. Throughout the survey, the facility was unable to provide nursing documents related to Resident #3's management.

In an observation of the inside of the kitchen cabinet door on at 5:20 PM, a paper was posted on the door with a blue box drawn around a sliding scale for , which listed the following: 100 to 150 - 8 units; 151 to 200 - 9 units; 201 to 250 - 10 units; 251 to 300 - 11 units. Plus 8. 1 unit over 150. There was writing observed below the paper, written in dry-erase marker, which stated, "Give 30 units at bed. Please sign [unreadable]". This posted paper did not list a resident's name, but had a stamp from

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967433	07/19/2017
NAME OF PROVIDER OR SUPPLIER **M & J QUALITY CARE, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **13231 SW 278 TERRACE** **HOMESTEAD, FL 33032**	

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

the healthcare provider.

A review of the prescription label for Resident #3's Flexpen Inj 100 U/ML (units per milliliter) read, "inject per sliding scale - admin before meals and at bedtime 100-150=8units 151-200=9units 201-250=10units".

2. In an observation on at 12:20 PM of centrally stored medication, a pill organizer was observed for Resident #4.

In an interview on at 12:25 PM, Staff C stated that Resident #4's medications were placed in the pill organizer by Resident #4's daughter. In an interview at this time, Staff C stated that facility staff take Resident #4's medication out of the pill organizer twice daily (morning and night) and then staff place the medication into a little cup, which the staff then hands to Resident #4. Staff C stated that none of the staff at the facility was a licensed nurse.

A review of Resident #4's health assessment, dated , did not have a box checked whether the resident needed assistance or did not need assistance with self-administration of medications.

3. In an interview on at 2:00 PM, Staff C stated Staff A was not a licensed nurse and that Staff A was a certified nursing assistant (CNA). In an interview at this time, Staff C stated that the documentation in Resident #7's record, listing glucose levels and units of for the months of , and , 2017, were written by Staff A.

In an observation on at 4:25 PM, testing strips that belonged to Resident #7 were observed in a kitchen cabinet. In an interview with Staff A at this time, she stated that they kept Resident #7's testing strips, even though he was no longer a resident, in case the facility needed to use the testing strips for another resident.

A review of Resident #7's file revealed that the file did not contain any documentation related to Resident #7's management by a licensed nurse. In an interview with the administrator on at 3:30 PM, they stated that the resident was receiving home health services for management. Throughout the survey, the facility was unable to provide nursing documents related to Resident #7's management.

In an interview with Staff C on at 2:05 PM, they stated that Resident #7 was admitted to the facility on .

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967433	07/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & J QUALITY CARE, LLC	13231 SW 278 TERRACE HOMESTEAD, FL 33032

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

A review of hospital records for Resident #7's hospital stay from to , revealed discharge orders that stated, "Arrange home health services. 15:15:00 EST for RN Management" with discharge plans to an assisted living facility. medication orders for Resident # 7 upon discharge were for the following two medications: 1) lispro (100 units/mL solution) 10 units, , 3 times a day before meals and 2) glargine (Lantus 100 units/mL solution) 30 units, , Daily at bedtime.

In an interview on at 9:30 AM, a Doctor who assessed Resident #7 prior to the resident going to the facility, stated that Resident #7 seemed to have a history of non-compliance with medications and had poorly controlled . In an interview at this time, the Doctor stated that Resident #7 was to take 4 injections a day, 3 before meals and 1 at night before bed. The Doctor stated that a home health script was written for Resident #7.

Class II

0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42(1-2) FS; 58A-5.033(3)(a) FAC

Based on observations, record review, and interview, the assisted living facility failed to ensure 3 of 7 residents received their medications by licensed personnel. Based on the above non-compliance the facility shall be required to employ the consultant services of a licensed pharmacist.

Findings include:

1. In an interview on at 1:15 PM, Staff D stated she sometimes helped Resident #3 with injections. In an interview at this time, Staff D stated that she was not a licensed nurse.

In an interview on at 1:15 PM, Resident #3 stated Staff A and D provide him with , dialed the pen to the correct amount, tell him a good spot on his body to inject, then hand him the pen and he injects the by pressing the button himself.

In a medication observation in Resident #3's at 5:05 PM, Staff D checked Resident #3's sugar level by pricking the resident's fingers multiple times. Staff D then decided to dial Resident #3' to 9 units based on the sugar level.

2. In an observation on at 12:20 PM of centrally stored medication, a pill organizer was observed for Resident #4.

In an interview on at 12:25 PM, Staff C stated that Resident #4's medications were placed in

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967433	07/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & J QUALITY CARE, LLC	**13231 SW 278 TERRACE HOMESTEAD, FL 33032**

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

the pill organizer by Resident #4's daughter. In an interview at this time, Staff C stated that facility staff take Resident #4's medication out of the pill organizer twice daily (morning and night) and then staff place the medication into a little cup, which the staff then hands to Resident #4. Staff C stated that none of the staff at the facility was a licensed nurse.

3. A review of Resident #7's file revealed that the file did not contain any documentation related to Resident #7's management by a licensed nurse. In an interview with the administrator on at 3:30 PM, they stated that the resident was receiving home health services for management. Throughout the survey, the facility was unable to provide nursing documents related to Resident #7's management.

A review of hospital records for Resident #7's hospital stay from to , revealed discharge orders that stated, "Arrange home health services. 15:15:00 EST for RN Management" with discharge plans to an assisted living facility. medication orders for Resident # 7 upon discharge were for the following two medications: 1) lispro (100 units/mL solution) 10 units, , 3 times a day before meals and 2) glargine (Lantus 100 units/mL solution) 30 units, , Daily at bedtime.

Class III

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

Based on interview and record review, the assisted living facility failed to have an up-to-date admission and discharge log that listed the names of all residents and each resident's date of admission and date of discharge for 2 former residents (Residents #6 and 7).

Findings include:

A review of the admission and discharge log on , documented that the facility did not list the admission or discharge dates for Residents #6 and 7.

In an interview with Staff C on at 1:30 PM, staff stated Residents #6 and 7 were each at the facility for a month.

In an interview with Staff C on at 2:05 PM, staff stated Resident #7 was admitted to the facility on .

In an interview with the Administrator on at 3:25 PM, the Administrator stated Resident #6 and

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967433	07/19/2017
NAME OF PROVIDER OR SUPPLIER **M & J QUALITY CARE, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **13231 SW 278 TERRACE** **HOMESTEAD, FL 33032**	

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

#7 had lived at the facility.

In an interview with Staff C on at 3:50 PM, staff stated that both Resident #6 and #7 were admitted to and discharged from the facility, but that both residents were not listed in the facility's admission and discharge log.

Class III

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 assisted living facility failed to submit an adverse incident report to the Agency after the elopement of a former resident (Resident # 7), in which the event was reported to law enforcement for investigation.

Findings include:

A review of police records for calls to service at the assisted living facility documented that Staff D called on at 4:27 PM to report that Resident #7 was last seen 4 hours prior.

In an interview with Staff B on at 12:15 PM, staff stated Resident #7 eloped from the facility when the resident went to buy cigarettes and did not return. In an interview at this time, Staff B stated that facility staff contacted police when Resident #7 eloped. Staff B stated that the police were able to locate Resident #7, Resident #7 then went to the hospital and did not return to the facility after the hospital stay.

A review of Resident #7's record documented a paper stating, "Eloped. Found by police. Went to hospital. Saturday -Eloped. - went to hospital. DC from facility".

A review of the Agency's adverse incidents database revealed the facility did not submit a 1-day or 15-day adverse incident report to the Agency following the elopement, law enforcement response and transportation to hospital for Resident #7.

In an interview on at 1:45 PM with Staff C, staff stated the facility did not report Resident #7's elopement as an adverse incident because the resident wasn't injured or harmed.

In an interview with the Administrator on at 3:25 PM, staff stated that there was no adverse incident report submitted for Resident #7's elopement.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967433	**07/19/2017**
NAME OF PROVIDER OR SUPPLIER **M & J QUALITY CARE, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **13231 SW 278 TERRACE** **HOMESTEAD, FL 33032**	

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

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967433	**07/19/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & J QUALITY CARE, LLC	**13231 SW 278 TERRACE HOMESTEAD, FL 33032**

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

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

Based on interview and record review, the assisted living facility failed to have signed attestations for 5 of 5 sampled staff (administrator, Staff A, B, C and D).

Findings include:

A review of employee files on for the Administrator, Staff A, B, C, and D did not contain signed attestation forms.

In an interview with the Administrator on at 3:50 PM, the Administrator stated that she could provide the attestations, however, the attestations she provided were from the Department of Elder Affairs and not from the Agency for Healthcare Administration.

Unclassified

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

Based on observation, interview, and record review, the assisted living facility failed to have an eligible background screening for 1 of 5 sampled Staff (Staff A).

Findings include:

A review of the Background Screening's Clearinghouse database on revealed Staff A's determination was, "A New Screening is Required".

In an interview with the Administrator on at 3:50 PM, the Administrator stated Staff A's background screening had expired in .

In an observation on at the facility, Staff A was observed to have direct contact with residents, by providing assistance with activities of daily living and assistance with self-administration of medications.

Unclassified