STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967433	R 08/21/2017

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)

0000 - Initial Comments

A monitoring revisit survey was conducted at M & J Quality Care, Llc (lic 11517) on and was concluded on . M & J Quality Care, Llc had deficiencies at the time of the survey.

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

Based on interview and record review, the assisted living facility failed to have a completed 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 included:

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 interview with Staff C at 2:10 PM, she stated that the only health assessment they had for Resident #4 was the health assessment dated .

Uncorrected Class III

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

Based on interview and record review, the assisted living facility failed to provide documentation that qualified licensed personnel were administering and managing medications for 1 of 8 sampled residents (#3).

Findings included:

In an interview on at 1:20 PM, Staff B and Staff C stated that Resident #3's private caregiver signed paperwork, documenting Resident #3's glucose and administration amounts during the month of 2017 and that Resident #3's private caregiver is a CNA (certified nursing assistant) and not a nurse.

In an interview with Staff C on at 1:30 PM, she stated that the facility provided Resident #3 with a 45-day discharge notice, in the event that the resident's doctor would not provide a prescription for nursing services, and Resident #3 would not be able to stay at the facility because there are no licensed nurses at the facility to administer the to Resident #3.

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In an interview with Resident #3's Power of Attorney on at 1:40 PM, she stated that a nursing consultation, pertaining to Resident #3's administration, was scheduled for at 4:00 PM. In an interview at this time, Resident #3's Power of Attorney stated that the doctor changed the order to twice a day, instead of four times a day, to allow for the coordination of home health nursing services twice daily.

Record review revealed the facility did not have any documentation to show that Resident #3 was receiving injections or that sugar levels were being taken.

Uncorrected Class III

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 was required to employ the consultant services of a licensed pharmacist by , but failed to employ the consultant services before the required date.

Findings included:

In an interview on at 1:20 PM, Staff B and Staff C stated that Resident #3's private caregiver signed paperwork, documenting Resident #3's glucose and administration amounts during the month of 2017 and that Resident #3's private caregiver is a CNA (certified nursing assistant) and not a nurse.

Record review revealed the facility did not have any documentation to show that Resident #3 was receiving injections or that sugar levels were being taken.

In an interview on at 1:35 PM with Staff C, she stated that the Pharmacist was coming to the facility on to review the Medication Observation Records and conduct the consultation for the medication training. Staff C did not know pharmacist's name in an interview at this time.

In an interview with a pharmacy representative on at 1:40 PM, she stated that a Pharmacist was going to the facility on at 3:00 PM.

Uncorrected Class III

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

Based on observation and record review, the assisted living facility failed to a written work schedule that reflects its 24-hour staffing pattern for a given time period.

Findings included:

On at 12:15 PM observed one staff member in the facility with four residents at the time.

A review of the employee schedule documented that the Administrator was working from 11:00 AM to 1:00 PM on . During the survey on , the administrator was not observed at the facility between the entrance interview at 12:15 PM and the exit interview at 3:00 PM.

Class III

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

Based on observation, interview and record review, the assisted living facility failed to have an up-to-date admission and discharge log. The facility failed to document each resident's date of admission for 1 of 4 sampled residents (Residents #4).

Findings include:

In an interview with Resident #4 on at 3:15 PM, the resident stated that they moved to the licensed facility in 2016.

A review of the admission and discharge log on , documented that the facility did not list the admission date for Resident #4.

In an interview with Staff C on at 1:25 PM, she stated that there were 4 residents living at the facility (Residents # 1, #3, #4 and #5).

In an observation of Staff C on at 1:25 PM, Staff C was unable to find Resident #4 listed on the facility's admission and discharge log.

Uncorrected Class III

0162 - Records - Resident - 58A-5.024(3) FAC

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Based on record review and interview, the assisted livng facility failed to have an updated health assessment for 1 of 8 after a hospice admission (Resident #2).

Findings included:

In an interview with Staff A on at 12:15 PM, she stated that Resident #2 had recently .

In an interview with Staff C on at 2:45 PM, she stated that Resident #2 had been a hospice patient but did not know when the resident was admitted to hospice.

A review of Resident #2's most recent health assessment, dated , did not document the resident was receiving hospice care.

In an interview with the hospice supervisor on at 12:15 PM, she stated that Resident #2 was admitted to hospice on and on .

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.

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 with Staff C on at 1:30 PM, she stated that the facility did not submit an adverse incident report for resident #7's elopement.

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In an interview with Staff C on . . . . . at 2:50 PM, Staff C stated that they could not locate the facility's policies and procedures for adverse incidents or resident elopements.

Uncorrected Class III

0167 - Resident Contracts - 58A-5.025 FAC

Based on interview and record review, the facility failed to have a contract addendum that was dated and signed by the facility and the resident or resident's legal representative for 4 of 8 residents (Resident #1, #3, #4, and #5)

Findings included:

A review of records for Residents # 1, #3, #4 and #5 contained a document titled, "Addendum to the M & J Resident's ALF contract 2008". The contract addendum stated, "This contract is between M & J Quality Care LLC and _____. This addendum shall become effective as of today, ___, 2017". A review of the contract addendum did not have the names of Residents #1, #3, #4 and #5 written in the blank space stating the parties who were involved in the contract.

In an interview with Staff C on at 1:40 PM, she stated that Residents #1, #3, #4 and #5 did not sign the contract addendums and the resident signature space, located at the bottom of the contract addendum, was filled out by Staff C for each of the 4 residents' contract addendums.

In an interview with Resident #4 on at 12:35 PM, the resident stated that she did not sign the contract addendum document and was not given any additional information by the facility staff on changes to the resident contracts.

Class III

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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 completed and signed attestations for 1 of 5 sampled staff (Staff D).

Findings included:

A review of employee files on . . . . . for the Staff D's attestation, signed . . . . , was incomplete. Staff D's attestation was AHCA Form #3100-0008, ⌣ 2010, which is not the most recent Agency attestation form.

In an interview with Staff B and C on . . . . at 1:20 PM, they verbally acknowledged that Staff D's attestation form affidavit was not completed.

Uncorrected Unclassified