STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911409	**08/24/2017**
NAME OF PROVIDER OR SUPPLIER **PROFESSIONAL HOME CARE II**	STREET ADDRESS, CITY, STATE, ZIP CODE **447 EAST 31 STREET** **HIALEAH, FL 33013**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

A standard biennial survey was conducted on , 2017 and concluded on , 2017. Professional Home Care with limited nursing services component (license number 91) had the following deficiencies identified at the time of the survey:

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

Based on observation and record review, the Assisted Living Facility failed to have a completed health assessment for one (#2) out of 14 sampled residents.

Findings included:

Observation on at 8:46 AM revealed Staff C, who was a Registered Nurse, assisted Resident #2 with self-administration of medication. Resident #2 was able to take the medications to the mouth without any help.

Review of Resident #2's record revealed that Health Assessment (AHCA form 1823) completed on indicated Resident #2 needed help taking the medications. It did not indicate what kind of help Resident #2 needed; it was left blank.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the Assisted Living Facility failed to keep medicines locked at all times.

Findings included:

Observation on at 6:51 AM revealed Staff G placed medications inside the stove in the kitchen.

In an interview on at 6:53 AM Staff G stated while referring to two boxes, "these are the pm medicines and those are the am medicines."

Observations on at 6:54 AM revealed that there were multiple little containers which were hand written and labeled with residents' names. Those containers had pills inside. There were medicines labeled with Resident #1's name; medications were Bee Pollen 500 mg and Allerclear (Loratidine tablets 10 mg) in one of the drawers in the kitchen. There was a drawer in the kitchen with ,

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and Inhalation Solution, Solution, , 500 mg, Odor Free Asperdreme with 4% Maximum Stregth- Pain relieving cream, Pain Relieve- , 500 mg, and .

Class III

0057 - Medication - Over The Counter (OTC) Products - 58A-5.0185(8) FAC

Based on observation and interview, the Assisted Living Facility failed to label over the counter products with the residents' name.

Findings included:

Observation on at 6:54 AM revealed that were in a drawer in the kitchen , 500 mg, Odor Free Asperdreme with 4% Maximum Strength- Pain relieving cream, Pain Relieve- , 500 mg, and . The medications were not labeled with residents' name.

In an interview on at 3:00 PM the Manager did not answer.

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 that residents received their medications as prescribed. Based on the above non-compliance the facility shall be required to employ the consultant services of a licensed pharmacist.

Findings included:

Observation on at 6:51 AM revealed Staff G placed medications inside the stove in the kitchen.

In an interview on at 6:53 AM Staff G stated while referring to two boxes, "these are the PM medicines and those are the AM medicines."

Observation on at 6:54 AM revealed that there were multiple little containers which were hand written labeled with the residents' names.

In an interview on at 6:52 AM Staff G revealed she gave the medications for the night shift.

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Staff G further stated, "The Administrator gave the prepared medicines to me. There was no MORs (medication observation records). I did not sign any book when I give the medicines."

On /1 at 8:04 AM the Manager stated in reference to the Administrator, "He is out on vacation. He left yesterday. I don't know how they give medicines."

In an interview on at 8:45 AM Staff C (Registered Nurse/ owner of the facility) stated, "I like to take them (referring to the medications) from the (bingo) cards but if an employee will help with the med pass, I leave the medicines in the cups."

Record review revealed the facility did not have MORs for the residents in the facility. Review of Residents #3, #4, #5, #6 and #12's MORs for , 2017 revealed that medications for at 2 PM and 8 PM were not updated. Review of Residents #1, #7, #10, #13, and #14's MORs for , 2017 revealed that medications for at 8 PM were not updated. Review of MORs revealed that they did not show if the resident had for Residents #1, #3, #4, #5, #6, #7, #10, #12, and #14. Review of Residents #12 and #13's MORs did not include the names of the residents' health care provider or contact information.

Class III

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

Based on record review and interview, the Assisted Living Facility failed to be under the supervision of an Administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents. This is evident by having unknown and untrained person without a background screening caring for a census of 14 residents. Which resulted in residents at the facility not having accurate medication records or proof that the medications were given.

Findings included:

Observation on at 6:50 AM revealed Staff G was alone in the facility caring for 14 residents.

In an interview on at 6:52 AM Staff G stated, "I am alone now."

Record review revealed the facility did not have a record for Staff G. Record review found Staff G did not have an eligible Level 2 background screening. Further record review revealed Staff G did not have First Aid and ( ) training or a completed employment application.

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Staff G did not have proof of successfully completing the initial 4 hour training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The facility's Administrator failed to ensure that Staff G had the required training and met the background screening requirements prior to allowing Staff G to be left alone in the facility caring for the residents.

In an interview on at 12:05 PM the Manager stated, "I cannot find Staff G's record."

Observation on at 6:51 AM revealed Staff G placed medications inside the stove in the kitchen.

In an interview on at 6:53 AM Staff G stated while referring to two boxes, "these are the PM medicines and those are the AM medicines."

Observation on at 6:54 AM revealed that there were multiple little containers which were hand written labeled with the residents' names.

In an interview on at 6:52 AM Staff G revealed she gave the medications for the night shift. Staff G further stated, "The Administrator gave the prepared medicines to me. There was no MORs (medication observation records). I did not sign any book when I give the medicines."

On /1 at 8:04 AM the Manager stated in reference to the Administrator, "He is out on vacation. He left yesterday. I don't know how they give medicines."
In an interview on at 8:45 AM Staff C (Registered Nurse/ owner of the facility) stated, "I like to take them (referring to the medications) from the (bingo) cards but if an employee will help with the med pass, I leave the medicines in the cups."

Record review revealed the facility did not have MORs for the residents in the facility. Review of Residents #3, #4, #5, #6 and #12's MORs for , 2017 revealed that medications for at 2 PM and 8 PM were not updated. Review of Residents #1, #7, #10, #13, and #14's MORs for , 2017 revealed that medications for at 8 PM were not updated. Review of MORs revealed that they did not show if the resident had for Residents #1, #3, #4, #5, #6, #7, #10, #12, and #14. Review of Residents #12 and #13's MORs did not include the names of the residents' health care provider or contact information.

Review of Resident #1's record revealed the Health Assessment (AHCA form 1823) completed on showed a diagnosis of 's . Resident #1 received , care.

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Review of Resident #3's record revealed the Health Assessment (AHCA form 1823) completed on showed a medical history and diagnoses of , debility, , and right knee replacement. Resident #3 needed assistance with self-administration of medications.

Review of Resident #4's record revealed the Health Assessment (AHCA form 1823) completed on showed a medical history and diagnoses of Parkinson's , and . Resident #4 needed assistance with self-administration of medications.

Review of Resident #5's record revealed the Health Assessment (AHCA form 1823) completed on showed a medical history and diagnoses of , and . Resident #5 needed assistance with self-administration of medications.

Review of Resident #6's record revealed the Health Assessment (AHCA form 1823) completed on showed a medical history and diagnoses of type 2 on long term , lumbago. Resident #6 needed assistance with self-administration of medications.

Review of Resident #7's record revealed the Health Assessment (AHCA form 1823) completed on showed a medical history and diagnoses of ( ), , and in the left eye. Resident #7 needed assistance with self-administration of medications.

Review of Resident #10's record revealed the Health Assessment (AHCA form 1823) completed on showed a medical history and diagnoses of . Resident #10 needed total assistance with administration of medications.

Review of Resident #12's record revealed the Health Assessment (AHCA form 1823) completed on showed a medical history and diagnoses of 's ( ), and . Resident #12 needed assistance with self-administration of medications.

Review of Resident #13's record revealed the Health Assessment (AHCA form 1823) completed on showed a medical history and diagnoses of , and . Resident #13 needed assistance with self-administration of medications.

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Review of Resident #14's record revealed that Health Assessment (AHCA form 1823) completed on showed medical history and diagnoses of , and . Resident #14 needed assistance with self-administration of medications.

2. Observation on at 7:18 AM revealed Staff H arrived to the facility. Further observations found Staff H assisting Resident #3 on at 7:52 AM. Staff G and H were the only staff members in the facility on from 6:50 AM to 7:35 AM until Staff D arrived to the facility.

Review of Staff Member H's personnel file revealed the staff member was hired on . Staff H's personnel record did not have proof of an eligible background screening in the facility. The facility also did not have proof that Staff H completed the following training:
- control
- Reporting major incidents
- Reporting adverse incidents
- Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation
- Resident rights in an assisted living facility
- Recognizing and reporting resident , neglect, and ,
- Resident behavior and needs
- Providing assistance with the activities of daily living
- Facility's resident elopement response policies and procedures.
- /
- The facility's policy and procedures regarding ( ).

In an interview on at 12:06 PM the Manager stated, "If they not there, I don't know what to tell you."

Review of Florida Health Finder revealed the Administrator supervised two Assisted Living Facilities.

Review Background screening website for providers showed that facility's employee roster showed Staff B as Manager.

Review of Manager's personnel revealed that there was no proof that Manager completed the CORE training.

In an interview on at 9:57 AM the Manager revealed the Manager did not have CORE training

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and stated "I am doing the hours." In further interview at 9:58 AM the Manager stated, "I am an attorney but I don't have the proof here."

Class II

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the Assisted Living Facility failed to evidence of negative examination on an annual basis for one (I) out of nine sampled staff members as well as to have health care provider documenting that the individual does not have any signs or symptoms of communicable for one (H) out of nine sampled staff members.

Findings included:

Review of Staff I's personnel records revealed that there was no evidence of a negative examination annually. The last negative examination was dated .

Review of Staff H's personnel records revealed that there was no evidence of a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable and negative examination.

In an interview on at 12:11 PM the Manager revealed Staff I did not have the exam completed in 2017.

Class III

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

Based on observation, interview, 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 6:50 AM revealed Staff G was alone caring for 14 residents.

In an interview on at 6:52 AM Staff G stated, "I am alone now because I am leaving."

Observation on at 7:18 AM revealed Staff H arrived to the facility.

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In an interview on at 7:19 AM Staff G stated, "The schedule should be in the office."

The facility's staff schedule provided was for , 21- . The facility did not provide a copy of the staff schedule.

Observation on at 7:54 AM revealed Staff I arrived. Staff I revealed that Staff I worked from 7 PM to 7 AM but Staff I was supporting the rest of staff that day.

In an interview on at 7:58 AM the Staff I stated, "I work next door (another assisted living facility) but I cover when they need me here."

Observation on at 8:04 AM revealed the Manager arrived.

In an interview on at 12:04 PM the Manager revealed that Manager did not know what to say but Administrator should have it ready.

Class III

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

Based on observation and record review, the Assisted Living Facility failed to prepare and serve the therapeutic diet as ordered by the health care provider for two (#3 and #4) out of 14 sampled residents. The facility also failed to note substitutions before or when the meal is served.

Findings included:

1. Observation on at 12:11 PM revealed that Residents #3 and #4 ate puree food.

Review of Residents #3 and #4's records revealed that they did not have an order for puree food.

2. Review of facility record revealed that Menu posted in the bulletin board at the dining for

In an interview on 12:18 PM the Manager revealed that Manager did not know it has to be plan in advance.

Class III

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

Based on record review and interview, the Assisted Living Facility failed to document resident elopement response drills. The facility failed to have the annual satisfactory sanitary inspection and the annual satisfactory fire safety inspection. The facility also failed to have an emergency management plan approval.

Findings included:

1. Review of facility's record revealed that last elopement drills was on .

In an interview on at 11:58 AM the Manager revealed that maybe Administrator had them in another place.

2. Review of facility record revealed that Health inspection was unsatisfactory on and previous satisfactory inspection was on .

Review of facility record revealed that Fire satisfactory inspection was on .

In an interview on at 11:59 AM the Manager revealed Health department has not returned yet. Manager could not find the new fire inspection.

3. Review of facility records revealed the Comprehensive Emergency Management Plan was approved on .

In an interview on at 12:05 PM the Manager stated, "I cannot find it."

Class III

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

Based on record review and interview, the Assisted Living Facility failed to weigh residents receiving assistance with the activities of daily living semi-annually for two (#1 and #2) out of 14 sampled residents.

Findings included:

Review of Resident #1's record revealed that Resident #1 needed total care with all activities of daily living. The facility documented Resident #1's last weight was dated .

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Review of Resident #2's record revealed that Resident #2 needed assistance with all activities of daily living. The facility documented Resident #2's last weight was dated .

In an interview on at 1:04 PM the Manager revealed that the Manager thought hospice was responsible for weighing Resident #1. On further interview at 1:33 PM the Manager stated, "Resident #2 is also in hospice so it is probably the same. It is not here neither".

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 Assisted Living Facility failed to maintain the eligibility results of employee screening in the employees' personnel file for one out of nine sampled staff (Staff H). The facility failed to ensure that staff had signed Attestation of Compliance with background screening forms for one out of nine sampled staff (Staff G).

Findings included:

Review of Staff H's personnel record revealed that there was no proof of the eligibility results of employee screening in record.

Review of background screening database revealed Staff H's last screening was on .

Review of Staff G's personnel record revealed the signed Attestation of Compliance with background screening form was not in record.

In an interview on at 12:13 PM, the Manager revealed the Manager did not know what could happened that everything was missing.

Unclassified

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

Based on record review and interview, the Assisted Living Facility failed to maintain the employment status of all employees within the clearinghouse and any changes in status must be reported within 10 business days.

Findings included:

Review of the background screening database showed the facility's employee roster did not have Staff G, H, and I.

Review of Staff I's personnel file revealed staff was hired on .

Review of Staff H's personnel file revealed staff was hired on .

On at 7:54 AM the Staff I arrived and revealed that Staff I worked from 7 PM to 7 AM.

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On . . . . . at 12 PM the Staff H stated they worked in the facility since . . . . , (2017).

Unclassified

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

Based on observation, record review, and interview, the Assisted Living Facility failed to ensure that one (Staff G) out of nine sampled staff had an eligible Level II background screening result prior to providing care to residents.

Findings included:

Observation on . . . . . at 6:50 AM revealed Staff G was at the facility alone caring for 14 residents.

In an interview on . . . . . at 6:52 AM Staff G stated, "I am alone now."

Record review found the facility did not have a personnel record for Staff G available.

In an interview on . . . . . at 12:05 PM the Manager stated, "I cannot find Staff G's record."

Unclassified