STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965438	08/25/2017
NAME OF PROVIDER OR SUPPLIER **J R FAMILY CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1110 NORTHWEST 134TH AVENUE** **MIAMI, FL 33182**	

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

0000 - Initial Comments

A Standard Biennial Survey was conducted on . J R Family Care (license #9835) had the following deficiencies identified at time of the survey:

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

Based on observation, record review and interview, the facility failed to be under the supervision of an administrator who ensured its proper operation and maintenance. The administrator also failed to ensure the adequate supervision and care for five of five sampled residents (Residents #1, 2, 3, 4 and 5).

Findings included:

1)
During the facility tour on at 9:40 AM, observed one paper bag with Resident's #1 medications on top of the dining table. Inside of the refrigerator there were unlocked medications that belonged to Residents #2 and #3. Resident # 1 and #5's medications were stored in the dishwasher. The caregiver took two tablets of , out of the package that belong to Resident #1, and placed them in a small cup at 11:19 AM. Staff B said, "This is his pain medications scheduled at 12:00 PM." Staff B went to the kitchen and put the cup with the medications into an unlocked kitchen drawer.

Further observation on at 9:50 AM found Resident #1 lying in his bed. Staff B was observed feeding Resident #1 regular food at 12:00 PM. He received regular lunch (Fish (4 oz), white rice (1 cup), carrots (1/2 cup), mixed salad (1 cup), fruit cocktail (1/2 cup)), which was not pureed. He was unable to assist with his feeding.

Review of Resident #1's record document he was admitted to the facility on and has a diagnosis of , , , Parkinson's, of skin, , , and . The Health Assessment dated 11/ indicated he requires assistance with eating and supervision with the rest of the Activities of Daily Living (ADLs). The physician indicated low fat/low diet and assistance with medication. Hospice certification and Plan of Treatment, Certification period from to showed he was diagnosed with , , and . The physician ordered a puree diet and 'thick it', the resident needed , precautions.

In an interview conducted on at 11:00 AM, Nurse from hospice stated, "We do not assist Resident #1 with medications." In a further interview with the Hospice Nurse at 1:36 PM, she stated that

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965438	08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
J R FAMILY CARE	**1110 NORTHWEST 134TH AVENUE MIAMI, FL 33182**

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

Resident #1 had a , on the left leg and a on the right arm. She stated that the assisted living facility staff gave the routine medications to the residents, and she was not aware that they could not administer the resident's medications. A review of the hospice record showed that the resident was prescribed as needed. The Hospice Nurse stated that if the resident needed the , the facility staff would call the main number and a nurse would come down and administer it. The Hospice Nurse stated that the resident was not ambulatory and that a home health aide visited him once daily to bathe him. She stated that the facility staff fed the resident. She stated that the resident was prescribed a puree diet, and that he should have thickened liquids due to his , and she confirmed that the resident was at risk of choking if the diet instructions were not followed.

Interview conducted on at 11:45 AM, Staff B stated that "Resident #1 eats regular food. The physician ordered 'thick it' in his liquids but he did not need it. I administer his medications. He cannot hold a spoon or take pill with his hands. He needed total assistance."

Observation on at 1:30 PM showed that there was unlocked in the refrigerator, labeled for Resident #5. A review of resident records showed that there was none for Resident #5, and further review showed that there was also no Medication Observation Record for the resident. Staff B stated at 1:40 PM that the resident had been hospitalized on after he went to a doctor's appointment and his health care provider admitted him. There was no documentation related to the resident's hospitalization. Staff B "Resident #5 is independent with his medications. I give him his medications when he requests."

2)
Observed on between 9:40 am and 2:30 PM, the ceiling lamps located in the dining area and in the hall did not have bulbs. The ceiling lamps located in the living in resident's (# , #2 and #3) were missing the covers, exposing the light bulbs. The living was worn and in spots, covered with white sheets. The in the hall had mold on the ceiling. # 's closet did not have a door. On at 1:30 PM Staff B stated "The lamp located in the dining broken. The administrator is going to fix the and dining's lamp."

3)
Observation on at 9:40 AM showed that there were four residents in the facility. Staff B was caring for the residents. Staff D was observed walking in the facility and using resident's leaving the facility.

Interview conducted on between 9:40 am and 2:30 PM, Staff B stated that Staff D is not a

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965438	**08/25/2017**
NAME OF PROVIDER OR SUPPLIER **J R FAMILY CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1110 NORTHWEST 134TH AVENUE** **MIAMI, FL 33182**	

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

facility staff. "She sleeps and showers here sometimes. She uses the common area and residents' . She use one of the beds located in staff sleep here sometimes."

Staff record review showed that the facility did not have a personnel file for Staff D's (hired dated unknown). Staff C's record did not contain documentation of an employment application. Staff B's record (hired on) did not have documentation that she received 1 hour in-service training in control. The employee files for Staff A, B and C did not contain documentation of a signed attestation of compliance with background screening. A review of the background screening database showed Staff B's background screening status stated "A New Screening is Required". There was no documentation of an eligible Level II background screening for Staff D.

A review of facility records and of the Florida Health Finder database showed the administrator supervised three facilities and there was no documentation of an appointed manager.

4)
The facility's posted license expired on . The admission & discharge log did not include Resident #1 admitted on , Resident #2 admitted on , Resident #4 admitted on , and Resident #3 and #5 admission date unknown. There was no liability insurance, sanitation inspection and emergency management plan available for review. The fire inspection was dated and had four violations: No emergency plan, no fire alarm tests, documentation of fire drills over the prior 12 months was not present, the facility needed to provide an evacuation capability assessment. The facility also had no documentation of conducting at least two resident elopement prevention and response drills in the last 12 months. The last documented drill was conducted on .

Resident records review showed that Resident #2 admitted on , Resident #4 admitted on and Resident #5 admitted two months ago did not have a Health Assessment on record for review. The facility had not executed a contract with Resident #2. There was no documentation of the written informed consent for unlicensed staff to assist the resident with self-administration of medications for Resident #4 and #5. Resident #3's record did not contain documentation of his weight every six months. Resident #3 Health Assessment done on indicated that the resident needed assistance with the activities of daily living. Resident #5 was transferred to the hospital the day before the inspection. There was not documentation that his primary physician or family members were notified. Resident #1 and #5 had full bed rails attached to their beds. Their records did not have written physician's order for the use of full bed rails.

Interview conducted on at 1:30 PM, the Administrator stated "I brought the facility documents

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965438	**08/25/2017**
NAME OF PROVIDER OR SUPPLIER **J R FAMILY CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1110 NORTHWEST 134TH AVENUE** **MIAMI, FL 33182**	

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

home and I was unable to provide the documentation at the time of the survey."

Class II

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965438	**08/25/2017**
NAME OF PROVIDER OR SUPPLIER **J R FAMILY CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1110 NORTHWEST 134TH AVENUE** **MIAMI, FL 33182**	

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

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

Based on observation, interview and record review, the facility failed to maintain an accurate employee roster in the background screening clearinghouse database.

Findings:

On . . . between 9:40 am and 2:30 PM, observed staff A, B and D in the facility, using resident's leaving the facility.

A review of the background screening database showed that Staff B, Staff C or Staff D were not listed. Only staff A was listed.

Interview conducted on . . . . . between 9:40 am and 2:30 PM, Staff B stated that Staff D is not a facility staff. "She sleeps and showers here sometimes. She uses the common area and residents' . . . . . . She uses one of the beds located in staff . . . sleep here sometimes."

Unclassified

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

Based on observation, interview and record review, there was no documentation that two of four sampled staff had an eligible Level II background screening before providing care and services, or sharing common areas, with residents.

Findings:

Four residents were in the facility during the survey. Staff B was caring for the residents. Staff D was observed walking in the facility and using resident's . . . . . leaving the facility.

A review of the background screening database showed Staff B's background screening status stated "A New Screening is Required". There was no documentation of an eligible Level II background screening for Staff D.

Interview conducted on . . . . . between 9:40 am and 2:30 PM, Staff B stated that Staff D is not a facility staff. "She sleeps and showers here sometimes. She uses the common area and residents' . . . . . . She uses one of the beds located in staff . . . sleep here sometimes."

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965438	**08/25/2017**
NAME OF PROVIDER OR SUPPLIER **J R FAMILY CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1110 NORTHWEST 134TH AVENUE** **MIAMI, FL 33182**	

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

Unclassified