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	AL11966280	**10/13/2017**
NAME OF PROVIDER OR SUPPLIER **DAVISITO'S, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **6524 NW 197TH LANE** **HIALEAH, FL 33015**	

SUMMARY STATEMENT OF DEFICIENCIES
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0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview the assisted living facility failed to maintain the environment in good working order.

Findings included:

Observation on at 9:00 am revealed a black substance resembling mold inside the sink kitchen cabinet.

Interviewed on at 1:00 pm, Staff A stated, "I will paint it with a special paint."

Class III

0000 - Initial Comments

An Abbreviated Biennial relicensure Survey was conducted , 2017- , 2017 along with a complaint survey. Davisito's Inc (licensed # 10500) had deficiencies identified at time of the survey:

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

Based on observation, interviews, and record review, the facility failed to ensure the appropriateness for admission of two of six sampled residents (Residents #1 and 2). Resident #1 was nonambulatory on and after admission, required medication administration, and could not participate in her own care in any way.

Findings included:

Record review revealed that Resident #1's health assessment on admission (dated) stated, "Acute , , Failure, , , , , , , , and ." In addition, it stated, "Requires total assistance for dressing, bathing and toileting."

Record review revealed that Resident #1's record had a Doctor's Order on admission (dated on) that stated, "Please Crush mediations or empty capsules and give with food. Patient is on soft /puree diet. Please do not give pills to swallow may aspirate."

Interview on at 1:00 pm revealed that Staff C stated, "Resident #1 is total, she cannot move her arms and/or legs. We have to do everything for her."

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Observation on at 7:10 am revealed Resident #1 laid on a recliner. Resident #1 did not verbalize. Between the recliner and the Resident, some ants were crawling on top and bottom. Resident #1 had an Pump (Fanny Pack) laid on the floor instead of being elevated it. Further observation at 11:50 am revealed that Staff C was feeding Resident #1, who was not able to assist in the process.

Class III

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

Based on observation, interviews, and record review, the facility failed ensure the appropriateness of continued residency for one of seven sampled residents (Resident # 1) who had a and required an pump for . The facility also failed to maintain documentation of the day-to- day fluctuation in functioning of daily living activities.

Findings included:

Record review revealed Resident #1's home health progress notes from stated, "Patient presents pressure on the hip , both are round shape 2.0 cmx 0.2 cm x 0.3 cm irregular border and bed bound. The patient has a ( ) line inserted to right upper arm in place with no signs and symptoms (S/S) of leakage or blockage noted on assessment. Following medical doctor (MD) orders and prepared to infuse three mg dose."

Observation on at 7:10 am revealed Resident #1 laid on a recliner. Resident #1 had her arms and legs bent toward the left side of the recliner. Resident #1 did not verbalize. Between the recliner and the Resident, ants were observed crawling on the resident and on the recliner. Resident #1 had an Pump (Fanny Pack) which laid on the floor instead of being elevated. Further observations on at 11:50 am found Staff C feeding Resident #1 sitting on a recliner.

Nursing observations on at 8:30 am in # found Resident #1 sitting on in a leather recliner with ants crawling around and on the resident. There was an line on Resident #2's right arm and an pump on the floor pumping medication into the . The facility did not have a licensed nurse at the location checking on the that was running. Resident #1 was , her arms and legs had . The caregiver stated Resident #1 recently was in the hospital and that her daughters had refused to place their mother under hospice services. Further observations revealed Resident #1 had a

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on her right hip.

Interview on at 8:30 am Staff C stated, "Resident #1 had a on the left hip but was better that the right one and an agency was taking care of the wounds."

Phone interview on at 8:45 am the home health agency nurse stated, "The insurance has the orders because they take a long time to approve the care. I go there twice a day. She has a on the right hip and a on the left hip that used to be a . She is receiving 3 gm in 300 ml of normal to run 1 hours every 8 hours by the pump."

A review of Resident #1's home health records revealed that a home health care agency was providing the services. Further review revealed that resident #1's record did not have a home health order or care orders.

A review of facility policies and procedures revealed a description of a change : " Significant change means a sudden or major shift in behavior or mood, or deterioration in health status as unplanned weight change, condition, or , 3, or 4 pressure ." Further facility record review revealed that the admission policy stated, "In the event the resident becomes ill and/or requires services beyond those, which the facility can provide, the resident's next of kin, sponsor, legal guardian, and/or power of attorney will be notified immediately. Assistance will be given in affecting a transfer to another level of care with or inside or outside the facility."

Record review revealed Resident #1's health assessment (dated) revealed a medical history of Acute , Failure, , , , ( ), , and , ( ). In addition, it stated Resident #1 required total assistance for dressing, bathing and toileting. Resident #1's record had a doctor order (dated on) that stated, "Please crush mediations or empty capsules and give with food. Patient is on soft /puree diet. Please do not give pills to swallow may aspirate."

Interview on at 1:00 PM Staff C stated, "Resident #1 is total, she cannot move her arms and/or legs. We have to do everything for her."

A review of Resident #1's home health notes showed, "The nursing care started on , for 6 weeks of nursing visits. Resident #1's diagnosis was , , of , , , unspecified , stage. Cleanse hip wounds with NSS, apply Sintel to each and cover with foam dressing." Resident #1's home health last progress notes on stated, " Patient present , on the hip

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both are round shape 2.0 cm x 2.0 cm x 0.3 cm irregular border and flush line using SASH flush technique."

Class II

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

Based on observation, record review and interview the facility failed to treat three of seven of sampled residents with dignity and respect (Residents # 1, 2 and 4). Resident #4 was restrained by a bed rail that she couldn't remove without staff assistance. Resident #2, a seventh resident whom the facility was not licensed to serve, was sleeping on a sofa bed in insufficient space. Resident #4 had ants on her and her recliner.

Findings included:

Observation at 7:30 am revealed that Resident #4 was in bed with a full bed rail up. Resident #4 asked Staff C to take her out from the bed because Resident #4 could not get out of bed on her own. Record review showed that Resident #4 was not under hospice care.

Interviewed on at 7:30 am Staff C stated, "Resident #4 needs my assistance to come out from the bed."

Observation on at 8:00 am revealed that there was a sofa sleeper inside # # did not have the minimum amount of square feet of personal space identified by statute, to allow for two residents to live in the . Further observation showed that Resident # 2, who was identified as a day care client, was living in the facility and sleeping on the sofa bed.

Interviewed on from 7:10 am - 2:00 PM, Residents #2, 3, 4 and 5 stated that Resident #2 had lived in the facility for a long time in # .

A review of the resident record revealed that Resident #2 had a residency agreement and demographic documents dated on . Resident #4 had a half bedside rail order dated on .

Interviewed on at 2:30 PM, Staff A and B acknowledged that Resident #2 lived in the facility. Staff A also stated, " I bough online a half bed rail, and they sent me a full bed rail. I will buy a half bedside rail myself." In addition, Staff B stated, " I will exterminate those ants."

Interviewed on at 10:00 am, Staff (C and D) and Resident (#4) stated, "There are ants in the

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facility." Staff C stated, "The Administrator sprays to kill the ants."

Observation on from 10:00 am - 1:40 PM revealed that the facility had insects appearing to be ants. Observation revealed that Resident #1 was sitting (#) on a recliner with her feet and arms contracted with the insects walking between her and the chair.

A review of facility records and resident files revealed that the resident rights stated, "Resident shall not be deprived of any rights, benefits or privileges guaranteed by the law or by the constitution. Live in a safe and decent home, free form and neglect. Be treated with respect."

Class III

0031 - Resident Care - Third Party Services - 58A-5.0182(7) FAC

Based on interview and record review the facility failed to ensure that a third party (Home Health Agency) maintained documentation within the resident's record of the services provided to one of seven sampled residents (Resident #2).

Findings included:

Interviewed on at 7:30 am, Staff C revealed that Resident #2 received administration from a nurse from an agency.

Record review revealed that Resident #2's received administration from a home health agency; however, there was no documentation of an order in the resident's file.

Interviewed on at 11:54 am the Home Health Agency's Nurse revealed that Resident #2 did not have an order in her file.

Class III

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

Based on observation, record review and interview, the facility failed to ensure that licensed personnel administered medications to two of seven sampled residents (#1 and 3). Resident #1 was receiving from a pump, unsupervised by any licensed medical staff, and no facility staff was monitoring the resident. Resident #1 also had a , , (line) through which she was receiving medications while no medical or facility staff were present. Unlicensed staff administered oral medications to Resident #3.

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Findings included:

Observation on at 7:10 am revealed Resident #1 laid on a recliner. Resident #1 did not verbalize. Between the recliner and the Resident, some ants were crawling on top and bottom. Resident #1 was connected to an Pump (Fanny Pack), which was laying on the floor.

Observation on at 8:30 am, revealed Resident #1 sitting on in a leather recliner, and insects were crawling on the seat. There was a line in the resident's right arm and the ( ) pump was still on the floor pumping medication into the . There was no nurse checking on the that was running. Facility staff were not present, as they were moving through the facility attending to other tasks and to the care of Resident #1 was not able to be interviewed due to . Her arms and legs were contracted.

According to the Mayo Clinic, a line is a an inserted though the skin into a in the arm, then advanced into the body until it's tip is in a central that carries to the . It is used to deliver medication. Possible risks of using the line include , and clots.

According to the Food and Drug Administration (FDA), "An pump is a medical device that delivers fluids, such as nutrients and medications, into a patient's body in controlled amounts. An pump is operated by a trained user. Over the past several years, significant safety issues related to pumps have come to FDA's attention. These issues can compromise the safe use of external pumps and lead to over- or under- , missed treatments, or delayed ."

A review of the resident's record revealed that Resident #1's health assessment (dated on her admission,) stated, "Acute , Failure, , , , , and ." In addition, it stated, "Requires total assistance for dressing, bathing and toileting."

Interview on at by phone 8:45 am, the Home Health Agency Nurse stated, She is receiving , 3gm in 300 ml of normal to run 1 hours every 8 hours by the pump. I will get you the Director of Nursing's (DON's) agency phone number."

Observation on at 7:30 am revealed that the Medication Observation Record (MOR) signed as given by Staff C for the following medications:

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Resident #1 (20 mg, 0.5 mg, DR 20 mg and D

Resident #3 (500 mg, 10 mg, 100 mg and 750 mg)

Record review revealed that Resident #1's health assessment (dated) stated, "Needs Medication Administration."

2)
Observation at 8:30 am revealed that Staff C took a box of medication belonged to Resident #3. Resident #3 was sitting at the dining . Staff C took a spoon and gave Resident #3 each pill directly to her mouth."

Interviewed on at 8:30 am Staff C stated regarding Resident #3, "I have to give her the medication with the spoon; she cannot take the mediations to her mouth because she shakes."

Record review revealed that Resident #3's health assessment (dated) stated, "Needs Assistance with self-administration of Medication."

Interviewed on at 9:00 am Staff C stated, "I assisted with medications daily. I provide Residents (1 and 3) medications daily, too. I crush resident #1's medications and pour in an applesauce; she needs total assistance." I used a spoon to give medications to Resident #3.

Class II

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review and interview the provider failed to maintain an accurate, up-to date medication observation record (MOR) for six of seven residents (1,3,4, 5, 6 and 7).

Findings include:

Record review revealed that at 7:30 am on , the MOR had Residents #1, 3, 4, 5, 6 and 7's 8:00 am medications already signed as given.

Interview on at 11:00 am revealed that Staff C stated, "I signed because I was nervous."

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Class III

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

Based on observation and interview the facility failed to keep centrally stored medications locked up at all times.

Findings included:

Observation on at 7:51 am revealed several over the counter medication (unlocked) in the following areas:

In # inside a plastic nightstand (2 ointment diaper , Tilomol 0.5%, Balme Comple Protection and Pain relief."

had medications (, Ointment 250 mg, Selan Formula) on top of the dresser.

In the dining , there was a medication (BHR Pain Relief) on top of the office desk.

Resident #4's monthly medication was inside of the unlocked closet of # .

A bottle of pink stomach relief liquid (unlocked) was inside of the refrigerator.

Interviewed on at 1:00 pm, Staff A and Staff C stated, "Resident #4's daughter brought those medications."

Class III

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

Based on record review and interview the facility failed to maintain a current employee roster within the background screening clearinghouse database.

Findings included:

A review of the facility's records and of the background screening clearinghouse database revealed that the posted staffing pattern did not match the roster.

A review of the facility's roster in the Background Screening clearinghouse database revealed that Staff J, who no longer worked at the facility, was listed.

Interview on . . . at 1:00 pm Staff A stated, "That staff stopped working here a year ago. I have to take her out of the clearinghouse website."

Unclassified

Z828 - Administrative Fines; Violations - 408.813(3) FS

Based on observation, record review and interview the assisted living facility failed to obtain a licensure capacity increase prior to providing personal care, meals, and assistance with self- administration of medication for seven of seven residents (Residents# 1-7). The facility provided services to residents outside the current licensed capacity of six.

Findings included:

Observation on . . . at 7:05 am revealed that the facility had seven residents (Residents# 1-7). Further observation on revealed that there were six beds, one sleeper sofa, two folding beds and two mattresses in.

Observation on . . at 10:00 am revealed that there were medications stored in the office cabinet, which belonged to Resident # 2.

Observation on at 7:07 pm revealed that Resident #2 was sleeping in # on a sleeper sofa.

Record review showed that Resident #2 had an Adult Day Care Agreement dated on . . . , which

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stated, "The client shall be dropped off at 7:00 am and picked up by 7: pm. However, Resident #2 had a Residency Agreement dated on with a demographic document in file, too.

Record review revealed that Resident #2 had a Medication Observation Record (MOR).

Interviewed on at 7:33 am Resident #4 stated, "Yes, Resident #2 lives here with us since a long time ago. She lives in # , which is the to the main entrance. She is here daily and has her meals and medication, too.

Interviewed on at 7:35 am Resident #5 stated, "I know Resident #2, she lives here in # . She sleeps in a sofa bed; the staff opens at night and closes on the morning. Resident #2 goes to a daycare only one day a week, but she lives here and she is a resident like us. Staff takes care of her by assisting with shower, meals and medications. She absolutely lives here like me.

Interviewed on at 7:07 am Staff C revealed, "We have six residents and one daycare (Resident #2)." Then, Staff D stated, "Resident #2 had two nights sleeping here because her son could not pick her up." In addition, Staff C stated, "I did not say the truth because I do not want to get fired."

Interviewed on at 2:30 pm Staff A and C acknowledged that Resident #2 lived in the facility. In addition, Staff A stated, "Resident #2 had two contracts and two records because I was waiting on having an empty ."

Unclassified