STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968202	**10/06/2017**
NAME OF PROVIDER OR SUPPLIER **COMMUNITY ALF SERVICES, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1250 NW 126 STREET** **MIAMI, FL 33167**	

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

0000 - Initial Comments

An unannounced complaint investigation, CCR 2017010891, was conducted at Community ALF Services (license 12150) from . . . . to . . . . . Deficiencies were identified at the time of the survey:

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record reviews and interviews, the facility placed maintain the required written record and daily observation of 3 of 3 sampled residents (Resident #1, 2 and 3).

Findings included:

On . . . . . , at 3:15 PM, in an interview with the administrator, it was requested the facility provide current copies of resident files.

A review of Resident #1's file showed that the resident was admitted to the facility on . There was no documentation of any progress or observation notes.

A review of Resident #2's file documented that the resident was admitted to the facility on . . . . . .
The last progress or observation note for Resident #2 was completed on .

A review of Resident #3's file documented that the resident #3 was admitted to the facility on .
The last progress or observation note for Resident #3 was listed as being completed on . . . . . .

On . . . . . , at 5:50 PM, the Administrator stated she was unaware of needing to document resident observations and progress including contact with the resident's physician.

Class III

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

Based on record review and interviews the facility failed to treat one of five sampled residents with dignity and respect (Resident #5). Resident #5 was abandoned at a local emergency of an impending hurricane. When the hospital staff found that the resident was not in immediate need of medical care, he was taken to a homeless shelter without any of his person belongings, and was unable to find permanent housing.

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Findings include:

On , at 2:25 PM, Resident #5 stated the Administrator took him to the hospital even though he did not want to go. Resident #5 stated nothing was wrong with him, but that the administrator," just wanted to get rid of me."

A review of Resident #5's file documented his date of admission at the assisted living facility as . Resident #5's 1823 health assessment dated documented that the resident was legally and needed assistance with ambulation, eating, total assistance with transferring and was considered a risk.

On , at 3:15 PM, the Administrator was requested to provide the file for Resident #5. The Administrator stated that she had discharged the resident on for failure to pay. The Administrator further stated she was forced to call the police on to deal with Resident #5's behavior.

On , at 5:50 PM, the Administrator admitted she did not know the current location of Resident #5. The Administrator stated she was discharging Resident #5 for failing to follow the rules because he was not taking his medications or eating. The Administrator stated she was concerned Resident #5 might go into . The Administrator was asked if Resident #5 was and she stated, "No but he still might go into ." The Administrator stated she was forced to take Resident #5 to a local hospital for treatment on because he had not eaten.

Further record review of Resident #5's file revealed a letter dated , which stated Resident #5 was being discharged for failure to make a payment. The letter to Resident #5 did not include any documentation that it had been delivered to the Resident #5. Resident #5's demographic information did not list any emergency family contacts or case managers. Record review showed another letter dated , addressed to Resident #5, which stated the resident was being provided a 45-day notice of discharge. The letter did not show any documentation Resident #5 was provided a copy of the 45-day discharge.

A review of Resident #5's progress notes for showed a note saying, "Resident refused to sign out of the facility, resident called the police and resident did not eat." Resident #5's progress notes for stated, "Resident #5 will not stay at the facility and will be transported to the hospital." Resident #5's progress notes for documented, "Resident will not be allowed back to the facility."

A review of files from a local hospital regarding Resident #5 showed that the resident was dropped off at

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the hospital at 7:20 AM on . The hospital record stated that the person dropping off Resident #5 identified herself as the resident's daughter.

On at 9:30 AM, the Administrator reiterated Resident #5 was transported to the hospital for failing to eat or take his medication and being combative. When asked about the medication, the Administrator stated she did not have a list but the medications were brought to the facility by a local pharmacy. The Administrator stated she was concerned about Resident #5 going into because he had not eaten. The Administrator denied Resident #5 being . The Administrator denied telling the hospital she was Resident #5's daughter. The Administrator stated she had not gotten back in contact with the hospital or been in contact with anyone concerning Resident #5 since he was taken to the hospital. The Administrator stated Resident #5 knew the telephone number to the facility and had a business card in his pocket.

On , at 1:18 PM, in an interview with the local pharmacy, the local pharmacy denied providing any medication for Resident #5 and they have never made a medication delivery to the facility.

A review of local law enforcement records showed a 911 call on from the facility. The call was made by Resident #5. Law Enforcement documents they responded to find Resident #5 upset because the Administrator was "kicking him out of the facility."

On , at 4:23 PM, the risk manager of a local hospital stated the Administrator identified herself, when dropping off Resident #5 at the hospital; she was Resident #5's daughter. Resident #5 stated to the hospital staff he was brought to the hospital because he needed shelter from the hurricane. The manager stated the hospital examined Resident #5 and found nothing wrong with Resident #5. The manager stated the hospital did not have any telephone numbers to reach the sister. The manager stated Resident #5 was sent to a local emergency shelter based on the impending hurricane.

On , at 8:50 AM, a state health department representative stated Resident #5 was brought to the emergency hurricane shelter by ambulance from the hospital. The department stated they contacted local offices of state government for placement on behalf of Resident #5 because the resident did not have family or a case manager.

On , at 8:30 AM, Resident #5 stated he did not take any medication. Resident #5 stated he was legally . Resident #5 stated the facility's Administrator took him to the hospital but she did not stay with him. Resident #5 stated he heard the administrator tell the hospital she was his sister. Resident #5 stated the administrator was trying to kick him out of the facility. Resident #5 denied knowing the telephone number to the facility and he did not have a business card in his pocket. Resident #5 stated

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he does not have a case manager or family locally.

Class II

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

Based on record review and interviews the facility placed 3 of 3 residents (Resident #1, 2 and 3) at direct risk of harm by failing to maintain the required medication observation records (MORs).

Findings included:

On at 3:15 PM, in an interview with the administrator, requested the facility provide the resident records for all current residents.

A review of Resident #1's file documented that Resident #1 was admitted to the facility on . Resident #1's file did not contain any documentation of MORs having been completed.

A review of Resident #2's file showed that the resident was admitted to the facility on . Resident #2's last MOR was completed in , 2015.

A review of Resident #3's file showed that Resident #3 was admitted to the facility on . The last MOR was completed in , 2015.

On , at 5:50 PM, when asked about the missing MORs, the administrator stated she had updated MORs but was unable to provide them at the time of the investigation.

Class III

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

Based on record reviews and interviews, the facility failed to ensure that at least one staff member who had completed courses in first aid was in the facility at all times. The facility also failed to maintain an accurate written work schedule.

Findings included:

A review of the administrators employee file documented the administrator had a valid , , ( ) training record, but there was no documentation off a First Aid training record.

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A review of Staff B's employee file showed that there was no documentation of current First Aid Training.

A review of the facility's records showed that there was no documentation of a current, written facility work schedule.

On , at 5:50 PM, the Administrator stated the facility does not maintain a written work schedule and she was not aware it was required. The administrator stated she believed everyone had completed first aid training, but that she did not have documentation to support that it had been completed.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review and interviews, the facility failed to ensure 1 of 2 staff had completed the required in-service training related to resident rights, recognizing resident and neglect and activities of daily living (Staff B).

Findings include:

A record review of Staff B's employee file, showed Staff B's date of hire was . There was no documentation of Staff B having completed the required in-service training relating to resident rights, recognizing resident and neglect and activities of daily living.

On , at 5:50 PM, the Administrator stated Staff B had completed the training; she was not sure the location of the documentation.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on record review, observations and interviews, the facility failed to provide documentation that 1 of 2 sampled staff had completed the required 4 hours of training related to assistance with the self-administration of medication (Staff B). The facility also failed to provide documentation that showed 1 of 2 staff had completed the required 2 hours of annual continuing education training on assistance with the self-administration of medication (Administrator).

Findings included:

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On , at 5:30 PM, Staff B was observed providing medication to Resident #3.

A review of Staff B's employee file showed that there was no documentation of Staff B having completed 4 hours of required training related to assistance with self-administration of medication.

A review of the administrator's employee file showed non documentation of the administrator having completed the required 2 hours of annual training for the years 2013 and 2015.

On , at 5:50 PM, the Administrator stated that she and Staff B both handle medication and provide assistance with self-administration of medication. The administrator stated she was not sure why the documentation was not in the files.

Class III

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

Based on record review and interviews, the facility failed to maintain the required semi-annual weight record for 1 of 3 sampled residents who required assistance with activities of daily living (Resident #1). The facility also failed to ensure that three of three sampled residents had a current health assessment (Residents #2 and 3)

Findings included:

On , in a record review of Resident #1's file, the file documented Resident #1 was admitted to the facility on . A review of Resident #1's health assessment showed that the resident needed asssitance with activities of daily living (ADL). Resident #1's file did not contain any documentation of a weight record for Resident #1.

On , at 5:50 PM, the Administrator stated she thought the weight charts were up-to-date and she was not sure why they were not in the file.

A review of Resident #2's file, documented Resident #2's date of admission as . The health assessment was signed on by a physician. Resident #2's file did not include any additional or updated 1823 health assessments.

A review of Resident #3's file documented the resident's date of admission as . The health assessment was signed on by a physician. The file did not include any additional or updated health assessments.

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On . . . . . at 5:50 PM, the Administrator was asked about the updated 1823 health assessments for Residents #2 and 3. She stated, "I am not sure why I need to update them, I have the original". She further stated she does not have any additional health assessments to provide.

Class III