STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967433	R 11/09/2017

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 second revisit survey was conducted on , 2017 and concluded on 9th, 2017. M & J Quality Care, Llc (license #11517) had the following deficiencies identifies at the time of the survey:

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

Based on observation and record review, the Assisted Living Facility failed to ensure that residents met the admission criteria for one (#9) out of 11 sampled residents.

Findings included:

Observation on at 7:00 AM revealed Resident #9 rested in bed. Further observations on /1 at 10:00 AM found Staff B braiding Resident #9's hair.

Review of Resident #9's record revealed the admission date was on . Resident #9's health assessment (AHCA form 1823) completed on showed the resident needed total care for bathing, dressing, self-care, toileting and transferring. Resident #9 started receiving hospice services on . Review of hospice nursing note of showed that Resident #9 was total dependent for all activities of daily living.

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation and interview, the Assisted Living Facility failed to follow the correct procedure when assisting one out of 11 sampled residents with self-administration of medications (Resident #10).

Finding included:

Observation on at 8:19 AM revealed Staff A stood next to Resident #10. Staff A took out pills from medication cards. Staff A did not read the medications' labels. Resident #10 asked for a cup of water because the tea was too hot. Resident #10 swallowed six pills. Staff A initialed the medication observation records (MORs) for the medications.

Reconciliation of Resident #10's medications revealed that medications were: , , tab 5 mg- take one tablet by mouth daily, tab 325 mg- take one tablet by mouth twice a day, , tab 25 mcg- take one tablet by mouth daily, Pantropazole Ter 40

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mg- take one tablet by mouth daily, Tamsulin 0.4 mg capsule 4 mg- take one capsule by mouth twice a day, [illegible] tab 3.125 mg- take one tablet by mouth twice a day.

In an interview on [illegible] at 10:58 AM Staff A revealed Staff A did not read the medications because staff showed the medications to the resident.

Class III

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

Based on interview and record review, the Assisted Living Facility failed to have licensed staff to provide medication administration administration to one (#11) out of 11 sampled residents.

Findings included:

In an interview on [illegible] at 7:32 AM Staff B revealed that staff did the [illegible] treatment for Resident #11. Staff unlocked the medicine, took out the vial, opened it, squeezed it in the machine and put it on in the Resident.

In an interview on [illegible] at 8:09 AM the Staff B revealed that none of the staff were a Registered Nurse or Licensed Practical Nurse.

Review of Resident #11's Medication Observation Record revealed that there was a doctor order for [illegible].083%- inhale 1 vial via [illegible] every 8 hours.

Class III
Uncorrected

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

Based on record review and interview, the Assisted Living Facility failed to ensure that each resident's Medication Observation Records (MORs) included any known [illegible] for one (#1) out of 11 sampled residents. The facility failed to ensure that each resident's MORs included the name of the resident's health care provider and the health care provider's telephone number for one (#9) out of 11 sampled residents. The facility failed to immediately update each time the medication is offered or administered for two (#1 and # 9) out of 11 sampled residents. The facility failed to schedule the medications according to the doctor's orders for two (#4 and #11) out of 11 sampled residents.

Findings included:

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1. Review of Resident #1's MORs revealed it did not include any known ..... the resident may have.

2. Review of Resident #9's MORs showed that it did not include the name of the resident's health care provider nor the health care provider's telephone number.

3. Review of Resident #1's MORs revealed that , , 5 mg- take by mouth one tablet every evening was scheduled at 5 PM. It was not initialed as given on . Review of Resident #9's MORs revealed that , 2.5 mg- take by mouth one tablet every twelve hours was scheduled at 8 AM and 8 AM. It was not initialed as given on and at 8 PM. - instill 1 drop in both eyes at bedtime was scheduled at 8 PM. It was not initialed as given on .

In an interview on at 8:06 AM Staff D revealed that Residents took their medicines.

4. Review of Resident #10's MORs revealed that there was a doctor order for 0.1% one drop to right eye four time a day. It showed scheduled as morning, noon, evening and night. Review of Resident #11's MORs revealed that there was an order of .083%- inhale 1 vial via every 8 hours. It was scheduled at 8 AM, 4 PM and 8 PM. Resident #11 received one dose within 4 hours and another dose within 12 hours.

In an interview on at 10: 52 AM the Staff B revealed that facility will correct all deficiencies.

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 in a locked cabinet, locked cart, or other locked storage receptacle, , or area at all times.

Findings included:

Observation on at 6:52 AM the in front of the main entrance there was an office. Office's door was unsecured; the locked was opened. There were white paper bags with residents' medicines inside.

In an interview on at 11:23 AM Staff B revealed that staff knew the medicines needed to keep locked at all times.

Class III

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0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on record review and interview, the Assisted Living Facility failed to obtain a clarification order for a medication ordered as needed or notify the doctor of changes that needed with the orders for one (#9) out of 11 sampled residents.

Findings included:

Review of Resident #9's Medication Observation Records (MORs) revealed that there was an order for 50 mg- take one tablet by mouth every six hours. There was no documentation about the time that Resident took the medicine. There was an order for 8.6 mg- take one tablet by mouth every 6 hours as needed. It was scheduled at 8 AM and was iniated as given since thru . There was an order for Milk of Magnesia - take two teaspoonful by mouth every day as needed. There was an order for Ipatropium/Albut 0.5 mg- inhale 1 vial every 6 hours and every 4 hours as needed. It was scheduled at 7 AM and 7 AM was iniated as given since thru .

There was a doctor's order for 20 mg tablet- take four tablets by mouth every 12 hours If rate less than 60 and , less than . It was documented as given once a day and there was no proof that facility recorded the , and rate.

In an interview on at 8:09 AM the Staff B revealed that none of the staff were a Registered Nurse or Licensed Practical Nurse and Staff did not know about all the requirements for medications ordered as needed.

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 1 out of eleven 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 who provided onsite quarterly consultation from , 2017.

Findings included:

1. In an interview on at 7:32 AM the Staff B revealed that Staff did the treatment for Resident #11. Staff unlocked the medicine, took out the vial, opened it, squeezed it in the machine and put it on in the Resident.

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In an interview on at 8:09 AM the Staff B revealed that none of the staff were Registered Nurse or Licensed Practical Nurse.

Review of Resident #11's Medication Observation Record revealed that there was a doctor order for .083%- inhale 1 vial via every 8 hours.

2. Record review revealed the facility had a contract with a pharmacy. Record review revealed the facility failed to provide documentation of quarterly consultations.

Class III
Uncorrected

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

Based on observation, interview, 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:

Observation on at 6:50 AM revealed Staff D and E (Volunteer) were on duty.

In an interview on at 6:56 AM the Staff D stated, "Staff C is not here, I worked last night with the volunteer."

Observation on at 7:33 AM revealed that Staff A arrived.

Review of facility's record revealed that 2017 Staffing Pattern was posted in the bulletin board in the dining it showed that Staff D was scheduled to work on 11/ from 7 AM to 7 PM, Staff A was on call, Staff B was scheduled to work on 11/ from 10 AM to 7 PM and Staff C was scheduled on and from 7 PM to 7 AM. Staff E was not in the schedule.

Class III
Uncorrected

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

Based on record review and interview, the Assisted Living Facility failed to have a completed health assessment that included whether the individual will require any assistance with the administration of

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medication for two of 11 sampled residents (Resident #4 and #9).

Findings included:

Review of Resident #4's record revealed the health assessment (AHCA form 1823) completed on . . . showed that resident needed medication administration.

In an interview on . . at 8:52 AM Staff B revealed that it was the only health assessment for Resident #4. "We helped Resident #4 with the medicines. Doctor checked the wrong box again."

Review of Resident #9's record revealed that health assessment (AHCA form 1823) completed on . . . showed that resident needed help with the medications but it did not indicate what kind of help.

Review of Resident #10's record revealed that the informed consent to assist with medication by unlicensed personnel was not signed. It was dated .

Class III
Uncorrected

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 one (Resident # 7) out of 11 sampled residents, in which the event was reported to law enforcement for investigation.

Findings included:

The facility did not have evidence of submitting 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 on at 10:02 AM Staff B revealed that facility has not completed the incident report because they don't have the password to get in.

Class III
Uncorrected

0167 - Resident Contracts - 58A-5.025 FAC

Based on interview and record review, the Assisted Living Facility failed to have a contract addendum

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that was dated and signed by the facility and the resident or resident's legal representative for three (Resident #1, #4, and #10) out of 11 sampled residents.

Findings included:

A review of records for Residents #1, #4, #10 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, [redacted], 2017". A review of the contract addendum did not have the names of Residents #1, #4, and #10 written in the blank space stating the parties who were involved in the contract.

In an interview on [redacted] at 11:20 AM the Staff B revealed that will correct all the problems for the following visit.

Class III
Uncorrected