STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966576	**11/29/2017**
NAME OF PROVIDER OR SUPPLIER **CAROLINA'S CARE CENTER CORP #3**	STREET ADDRESS, CITY, STATE, ZIP CODE **8100 WEST 12 AVENUE HIALEAH, FL 33014**	

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

0000 - Initial Comments

A standard survey was conducted on , 2017. Carolina's Care Center Corp III with the Limited Mental Health component and license number 10766 had deficiencies identified at the time of the survey.

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

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Based on observation, record review and interview, the facility failed to maintain a written record of significant changes that resulted in hospitalization for two of five residents sampled (# 4 and #5) . The facility also failed to document weight changes after hospitalization for one of five residents sampled (#2).

Findings included:

Observation on at 10:00 am revealed that Residents #4 and #5 had their possessions in # and their medications centrally stored in the facility's medication cabinet.

Interviewed on at 10:00 am, Staff C stated, "Residents #4 and #5 were a couple, and they were at the hospitals."

A review of Resident #4's progress notes revealed that there was no documentation of the resident having been hospitalized.

A review of Resident #5's progress notes revealed that there was no documentation of the resident having been hospitalized.

A review of Resident #2's health assessment dated on showed that the resident weight 140 pounds ." The admission weight record showed a weight of 126 pounds dated on the same day, . The Resident's weight log showed that the resident weighed 128 pounds on . A review of Resident #2's progress notes did not show documentation of the resident's weight loss after hospitalization.

Interviewed on at 12:27 pm, Staff A stated that she did not know that she had to write hospital information in resident progress notes. Staff A also stated, "I write the information monthly, and when they come back from the hospital." In a further interview on at 12:27 pm, Staff A stated, "Resident #4 went to the hospital to get a , . Resident #5 went to the hospital due to , ."

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Staff A also stated, "The doctor does not use a scale, he estimates the weight by sight. I put the reading from the scale; however, I just will put the one the doctor writes and that's." Regarding Resident #2, Staff A stated, "Resident #2 lost weight at the hospital. When he came back from the hospital he was not eating. He is eating well, now. We encourage him to eat, and the doctor provided a medicine to help him; I follow all the precautions, but I did not document the action taken."

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966576	**11/29/2017**
NAME OF PROVIDER OR SUPPLIER **CAROLINA'S CARE CENTER CORP #3**	STREET ADDRESS, CITY, STATE, ZIP CODE **8100 WEST 12 AVENUE HIALEAH, FL 33014**	

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

Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on record review and interview, the facility failed to provide documentation of a signed Attestation of Compliance with Background Screening for one of four sampled staff (Staff A).

Findings included:

A review of the personnel record revealed that there was no documentation of a signed Attestation of Compliance with Background Screening for Staff A (hired).

Interviewed on at 12:00 pm Staff A stated, "I did not notice that I was missing the Attestation, I have blank copies of the form, and I can sign it right now."

Unclassified