STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967722	R 12/22/2017
NAME OF PROVIDER OR SUPPLIER **ADIUVO, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **6410 SW 63 AVENUE** **MIAMI, FL 33143**	

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

0000 - Initial Comments

A standard biennial revisit survey was conducted on and concluded on . Adiuvo, LLC. with a Standard license (#11728) had the following deficiencies found at the time of the survey:

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

Based on observation, interview, and record review, the facility failed to determine the ongoing appropriateness of continued placement for one out of five sample residents (Resident #4). The resident, who had been refusing to eat and drink for at least 2 weeks, at the facility on after screaming in pain for several hours.

Findings included:

On at 10:50 AM, during a routine revisit inspection, Staff B stated Resident #4 had , , and the resident's body was still in the resident's bed. Staff B further stated, "At 3:00 AM, Resident #4 was screaming in pain all night and I gave her a pill from another resident and went back to my . Then the resident got quiet. I did not go back to her later that morning around 6:30 AM, when I passed by and looked at her and she was in a sleeping position. I went to the kitchen to prepare breakfast for the residents who were going to the day program. I did not touch Resident #4. At around 7:00 AM or 7:30 AM, I went to Resident #4's bathe her. I called her and she did not respond. I found out that the resident , , and she was . I did not perform on her. I called 911. The operator asked me how the resident was and if I performed on her. I responded to the 911 operator the resident was totally inert and I did not perform on the resident. The 911 operator asked me, 'do you need an ambulance' and I told them 'no.' The police arrived between 8:30 to 8:40 A.M." Staff B repeated, "I did not perform on the resident."

A review of the police department call record showed, the police received the call from the facility regarding Resident #4's on at 8:30 am.

On at 10:50 AM, observed in # the remains of Resident #4 with half bed rails up. Resident #4's (Resident #1) was lying down in bed. At 11:00 AM, Resident # 1 stated," My was screaming all night and the staff came here to see her a few times."

On at 12:08 PM, Staff B stated, "Resident #4 was screaming 'give me a . I took a from Resident #1 and I gave it to Resident #4, and she (Resident #4) stayed quiet."

On at 3:25 PM, Resident #5, when asked if he had heard any noise, he stated, "We have a

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resident who has been screaming for a month. She is in intensive pain and was screaming all night. The female resident is , and sleeps near my , and she has been screaming all night because she is dying, not because she is mistreated."

On at 6:19 PM, Staff C stated, "I work during the weekends. I saw Resident #4 last Monday. She was in a bad health condition. The resident could not do anything on her own. We had to put the food in her mouth while she was in bed." I was giving a bath in bed to Resident #4 and I observed that she had difficulty swallowing." When asked, Staff C stated Resident #4 was not receiving hospice care. Staff C stated, "She had been screening from pain for over a week. She was screaming in pain during the night from Sunday to Monday. I did not offer any medication to Resident #4 because there was no pain medication ordered."

A review of Resident #4's record showed that on the weight was 118 pounds and seven months later, on , the resident was 84 pounds (a 34 pound weight loss).

On at 2:19 PM, the Administrator stated, "Resident #4 lost weight because she did not want to eat, drink or do nothing. She was refusing to eat, drink, and bathe. Of course if you don't eat or drink what will happened to you? You will lose weight." When asked why she did nothing and why she didn't obtain a new health assessment for Resident #4, the Administrator stated, "I didn't consider it a change of condition. Resident #4 was just like that."

Record review showed Resident #4 was admitted on . A health assessment dated on revealed, diagnoses of , and . The resident was oriented times one (the resident knew who she was). The resident needed supervision with dressing and eating, and required assistance with ambulation, bathing, self-care, toileting and transferring. Resident #4 needed assistance with self-administration of medication. A progress note written by the Administrator dated 11/ revealed, the resident's primary physician referred Resident #4 to the hospital rehabilitation center for . The note documented, "She was refusing to drink or eat." One month later, on , another progress note written by the administrator documented, "Resident #4 is refusing to eat or drink." The progress note further documentted, "Spends most of the nights screaming in pain. When you ask her what hurts, she says, 'nothing'."

A review of more progress notes in Resident #4's file showed, "On Resident #4 , in her sleep, sometime after 3:00 am. The caretaker checked on her at that time. The caretaker went to get her up at 7:15 am and discovered Resident #4 at that time, the police was called. The son was called and doctor, son called funeral home. Body picked up around 11:00 AM."

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A review of a hospital record for Resident #4 revealed, on at 11:10 AM, the female arrived by ambulance on a stretcher with pain at the emergency past medical history of , acute and who presents a 3 days onset of pain and . A computerized tomography scan (CT) of the abdomen and pelvis revealed . The hospital discharge instruction, orders and medications dated showed diagnoses: Gallstones; Elevated tropoin, ( ); Acute ( ); Cholelithiasis, . Resident #4's health assessment done on at the time of discharge showed, the sections indicating whether the individual's needs could be met in an assisted living facility were blank. The health assessment revealed, on discharge, the resident "needed complete assistance with activities of daily living (ADL's)."

A review of the hospital discharge records from a rehabilitation center for Resident #4's revealed, she was admitted on in the Emergency diagnoses of functional decline and disuse myopathy. The resident had discharge diagnoses of gait imbalance and activity of daily living . The resident was also diagnosed with a Sacral : ; a on the flank: and ; ; ; , Chronic iron deficiency , and a outbreak. According to the physician, patient had become and weak over the last few weeks and gradually worsened.

During an interview on at 1:40 PM, the Owner stated, the physician had referred Resident #4 to hospice care about 10 days earlier. A review of Resident #4's record showed no documentation that the facility physician had been contacted and there was no documentation that the resident received home health, care or hospice care.

During a phone interview on at 3:31 PM, a rehabilitation center doctor stated, "Resident #4 arrived to the hospital with a outbreak. The resident was referred to the doctor and she was placed on medication. The resident was weak, she was refusing to eat or drink, and she did not want to cooperate with treatment. I spoke with her primary doctor that did not want to send the resident to the nursing home because he was thinking that the resident will be better in the assisted living facility (ALF)."

Class I

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

Based on record review and interview, the facility failed to treat two out of five sampled residents with dignity and respect, free from and neglect. Resident #4 screamed in pain for many days until she . Resident #3 was left without one dose of her prescribed pain medication when it was given to

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Resident #4. The facility failed to protect four out of five sampled residents (Residents # 1, 2, 3, and 5) from a possible exposure to communicable when another resident was readmitted to the facility with a , Outbreak (Diagnosis of).

Findings included:

1) A review of the police department call record showed, the police received a call from the facility regarding Resident #4's on at 8:30 am.

On at 10:50 AM, observed in # the remains of Resident #4 with half bed rails up. Resident #4's (Resident #1) was lying down in bed. At 11:00 AM, Resident # 1 stated," My was screaming all night and the staff came here to see her a few times."

On at 12:08 PM, Staff B stated, "Resident #4 was screaming 'give me a . At 3:00 am, I took a from Resident #1 and I gave it to Resident #4, and she (Resident #4) stayed quiet." Staff B further stated, after giving Resident #4 the , she did not check on the resident again until after breakfast, around 7:30 am.

On at 3:25 PM, Resident #5 was interviewed, when asked if he had heard any noise, he stated, "We have a resident who has been screaming for a month. She is in intensive pain and was screaming all night. The female resident is , and sleeps near my , and she has been screaming all night because she is dying, not because she is mistreated."

On at 6:19 PM, Staff C stated, "I work during the weekends. I saw Resident #4 last Monday. She was in a bad health condition. The resident could not do anything on her own. We had to put the food in her mouth while she was in bed." I was giving a bath in bed to Resident #4 and I observed that she had difficulty swallowing." When asked, Staff C stated, Resident #4 was not receiving hospice care. Staff C stated, "She had been screening from pain for over a week. She was screaming in pain during the night from Sunday to Monday. I did not offer any medication to Resident #4 because there was no pain medication ordered."

In a phone interview on at 1:37 PM, when asked about facility policies, the Owner and the Administrator both stated, the facility's procedure was "to check on someone as often as needed if they're not doing well. If it is something beyond their scope, they contact 911 if the person isn't improving."

A review of Resident #4's record showed, on the residents weight was 118 pounds and seven

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months later, on , the resident was 84 pounds (a 34 pound weight loss).

Record review showed, Resident #4 was admitted on . A health assessment dated on revealed, diagnoses of , and . The resident was oriented times one (the resident knew who she was). The resident needed supervision with dressing and eating, and required assistance with ambulation, bathing, self-care, toileting and transferring. Resident #4 needed assistance with self-administration of medication. A progress note written by the Administrator dated 11/ revealed, the resident's primary physician referred Resident #4 to the hospital rehabilitation center for . The note documented, "She was refusing to drink or eat." One month later, on , another progress note written by the administrator documented, "Resident #4 is refusing to eat or drink." The progress note further stated, " Spends most of the nights screaming in pain. When you ask her what hurts, she says 'nothing'."

On at 2:19 PM, the administrator stated, "Resident #4 lost weight because she did not want to eat, drink or do nothing. She was refusing to eat, drink, and bathe. "Of course if you don't eat or drink what will happened to you? you will lose weight."

A review of the hospital discharge records from a rehabilitation center for Resident #4 revealed, she was admitted on in the Emergency diagnoses of functional decline and disuse myopathy. The resident had discharge diagnoses of gait imbalance and activity of daily living . The resident was also diagnosed with a Sacral : ; a on the flank: and ; ; ; , Chronic iron deficiency , and a outbreak. According to the physician, the patient had become and weak over the last few weeks and gradually worsened.

During an interview on at 1:40 PM, the Owner stated, the physician had referred Resident #4 to hospice care about 10 days earlier. A review of Resident #4's record showed no documentation that the facility physician had been contacted and there was no documentation that the resident received home health, care or hospice care.

2) During the medication reconciliation on , it was found that Resident #3 had a medication order for - , 37.5-325- give one tablet by mouth every 8 hours. The resident's diagnosis was: "pain". The medication card revealed, it had a label that was dispensed on and for 31 tablets, 15 tablets were taken out of the medication cards.
During an interview on at 11:10 AM, Staff B stated, "a program discharged the medicine from every 8 hours to two times a day, since last month, but they did it by phone." She revealed, she was not a License Practical Nurse (LPN) or Registered Nurse (RN) in the United States of America(USA). At

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11:13 PM, She stated, the pharmacy did not send the , card for the 2 PM dose; and it was not in the facility.

In an interview on Friday, , 2017 at 3:00 PM, the prescriber stated, Resident #3 would have experienced more pain that usual by missing the 2:00 PM dosage.

3) During a phone interview on at 3:31 PM, a rehabilitation center doctor stated, "Resident #4 arrived to the hospital with a outbreak". The resident was referred to an doctor and she was placed on medication. He stated, "resident was weak, she was refusing to eat or drink, and she did not want to cooperate with treatment." I spoke with her primary doctor that did not want to send the resident to the nursing home because he was thinking the resident will be better in the assisted living facility (ALF).

In an interview with the health department on , 2017 at 12:07 PM, the health officer stated, , / was , and could cause anyone who hadn't previously had chicken , to develop them.

Class I

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

Based on observation, record review, and interviews, the Administrator failed to ensure the management of all staff and the provision of appropriate care to all residents as required by the Assisted Living Facility rules and statutes. Resident #4 (one of five sampled residents) in the facility after refusing to eat or drink for several days, and after screaming in pain all night. Inadequately trained facility staff gave the resident medication that belonged to another resident, failed to maintain awareness of her health condition during the night, and failed to provide , ( ) upon discovering the resident unresponsive. The facility also failed to ensure the resident received a needed, higher level of care before her .

Findings included:

1) Training:

A review of staff records showed the Administrator, Staff B and C did not have and First Aid training from an approved provider. The and First Aid training found in their records was online training date issued , , 2017 expiration date , , 2019. This online provider is not an approved provider.

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Regarding Resident #4's in bed on , Staff B reported on at 10:50 am "At around 7:00 AM or 7:30 AM, I went to Resident #4's bathe her. I called her and she did not respond. I found out that the resident , , and she was . I did not perform on her. I called 911. The operator asked me how the resident was and if I performed on her. I responded to the 911 operator, the resident was totally inert and I did not perform on the resident. The 911 operator asked me, 'do you need and ambulance' and I told them, "no." The police arrived between 8:30 to 8:40 A.M." Staff B repeated, "I did not perform on the resident."

On at 1:13 PM, when asked if Resident #4 had a ( ), the Administrator stated, "Resident #4's son never signed a ."

2) Medication:

Record review showed the Administrator, Staff B and C did not have the required two hours of continuing education training regarding self-administration of medication in an assisted living facility. The administrator's medication training was dated , Staff B's medication training was dated (4 hours) and Staff C's assistance with self- administration of medication training was dated (4 hours).

On at 12:08 PM, Staff B stated, regarding the , "Resident #4 was screaming, "Give me a . I took a from Resident #1 and I gave it to Resident #4, and she stayed quiet." A review of Resident #4's Meditation Observation Record and facility record showed there was no documentation indicating Resident #4 was prescribed or authorized to take it as an over the counter medication.

On at 6:19 PM, Staff C stated, "I work during the weekends. I saw Resident #4 last Monday. She had been screaming from pain for over a week. She was screaming in pain during the night from Sunday to Monday. I did not offer any medication to Resident #4 because there was no pain medication ordered."

On at 10:50 AM, observed unlocked medications for Resident #4 in Staff B's , and over-the-counter meditations (OTC) without labels that identified the medications' owners.

Medication reconciliation showed Resident #3 had a medication order for - , 37.5 mg/-325 mg, with instructions stating, 'give one tablet by mouth every 8 hours.' The resident's diagnosis was: "pain". The medication card revealed, 31 tablets were dispensed on . Observation showed that 15 tablets were taken out of the medication cards. A review of the health

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assessment showed that Resident #3 was diagnosed with and other conditions. In an interview on , a representative from Resident #3's day program stated, the resident had generalized chronic pain. Missing a dosage of the medication would cause an increase in pain.

During an interview on at 11:10 AM, Staff B stated, "the day program discontinued the 2:00 PM dosage of the medicine, changing it from every 8 hours to two times a day since last month. But they did it by phone." Staff B revealed, she was not a License Practical Nurse (LPN) or Registered Nurse (RN). At 11:13 PM, Staff B stated, the pharmacy did not send the , card for the 2 PM dose; and it was not in the facility.

During a phone interview on at 11:18 AM, a staff person at the day program for Resident #3 stated, she'd reviewed Resident #3's record going back to , 2017, and there had been no changes in the order. The 2:00 PM dosage had not been discontinued.

During a phone interview on at 12:50 PM, the pharmacist revealed, , was delivered on to the facility in three medication cards containing 31 tablets each, and the doctor's order was for the resident to take the medication every 8 hours.

During a phone interview on the afternoon of , Resident #4's physician stated, he had prescribed Ensure one to three times per day and the medication , 50 mg once per night for , and to increase the resident's appetite. A review of the Medication Observation Record showed, there was no documentation of Ensure or , being given to the resident.

On At 11:25 A.M., observed Staff B taking bottles of medications for Resident #4 to the kitchen counter and poured all the pills in a plastic container. The Administrator, who was sitting in the dining area, did not intervene to stop the staff person or to provide information about how to correctly dispose of the medication.

On at 12:03 P.M., when asked where Resident is #4 medications were, Staff B stated, "I discarded Resident #4's medications."I do not dump the medication in the or hand sink to prevent contamination to the water or the environment, I bury medication in the backyard."

On at 10:06 am, when asked to retrieve the plastic container where she had poured all of Resident #4's medications so that they could be reconciled, Staff B stated, "I put them underground yesterday because when a resident two years ago, a woman told me to do it in that way." Observation showed, the medications were retrieved from where they were buried in the back yard were no longer in a plastic container. The medications had already begun to decompose and were unable to

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be reconciled.

On at 10:20, observed that one pill from a prescription for 7 tablets of for Resident #5 was missing from the medication pack. When asked where the missing pill was, the Administrator was unable to account for it.

3) Health Assessment and changes of condition:

Record review showed, Resident #4 was admitted on . A health assessment dated revealed, diagnoses of , and . The resident was oriented times one (knew who she was). The resident needed supervision with dressing and eating, and required assistance with ambulation, bathing, self-care, toileting and transferring.

A review of Resident #4's record showed, on the weight was 118 pounds and seven months later, on , the resident was 84 pounds (a 34 pound weight loss). There was no documentation of any intervention regarding the resident's substantial weight loss.

On at 2:19 PM, the Administrator stated, "Resident #4 lost weight because she did not want to eat, drink or do nothing. She was refusing to eat, drink, and bathe. Of course if you don't eat or drink what will happened to you? You will lose weight". When asked why she did nothing and why she didn't obtain a new health assessment for Resident #4, the Administrator stated, "I didn't consider it a change of condition. Resident #4 was just like that." The facility did not have any documentaiton that Resident #4's doctor was contacted regarding the change of condition.

On at 3:25 PM, Resident #5 when asked if he had heard any noise the night before he stated, "We have a resident who has been screaming for a month. She is in intensive pain and was screaming all night." "The female resident who is and she has been screaming all night because she is dying, not because she is mistreated".

A review of the hospital discharge records from a rehabilitation center for Resident #4's revealed, she was admitted on in the Emergency diagnoses of functional decline and disuse myopathy. The resident had discharge diagnoses of gait imbalance and activity of daily living . The resident was also diagnosed with a Sacral ; a on the flank: and ; ; ; , Chronic iron deficiency , and a outbreak( ). According to the physician, the patient had become and weak over the last few weeks and gradually worsened.

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A review of a hospital record for Resident #4 revealed that on at 11:10 AM, the female arrived by ambulance on a stretcher with pain at the emergency past medical history of , acute and who presents a 3 day onset of pain and . A computerized tomography scan (CT) of the abdomen and pelvis revealed . The hospital discharge instruction, orders and medications dated showed diagnoses: Gallstones; Elevated tropoin, ( ); Acute ( ); Cholelithiasis, . Resident #4' s health assessment done on at the time discharge showed, sections indicating whether the individual's needs could be met in and assisted living facility were blank. The health assessment revealed, on discharge, the the resident "needed complete assistance with activities of daily living (ADL)."

During an interview on at 1:40 PM, the Owner stated, the physician had referred Resident #4 to hospice care about 10 days earlier. A review of Resident #4's record showed no documentation the facility physician had been contacted and there was no documentation that the resident received home health, care or hospice care.

A review of the demographic information sheet for Resident #4, followed by an attempt to contact the primary care physician listed there revealed, the physician had not worked with the resident since 2016. There was no documentation of an updated contact for Resident #4's physician.

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