STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969108	12/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AN EXCELLENT CARE ALF LLC	**16251 SW 248TH ST HOMESTEAD, FL 33031**

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

A complaint (CCR#2017011213) survey was conducted on , 2017 and concluded on , 2017. An Excellent Care Alf Llc with license #12933 had the following deficiencies identified at the time of the survey:

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

Based on record review and interview, the Assisted Living Facility (ALF) failed to ensure that two out of seven sampled residents received medical attention as needed (#4 and #6). Residents #4 and #6 were residents. Resident #6 was hospitalized with a critically low sugar level. Resident #4 was without receiving administration for two days.

Findings included:

In an phone interview on at 10:50 AM Resident #6's family member revealed that the resident went to the hospital because of really low sugar and stayed there for a long time.

A review of Resident #6's hospital record revealed on fire rescue arrived to the facility, the Resident's sugar level was 20 mg/dl (normal sugar range for an adult is 70-100 mg/dl). Resident #6 arrived to emergency department at 1:22 PM and revealed that s/he did not not eat breakfast that morning. The hospital administered glucose and , and the resident's glucose level went up to 40 mg/dl. A second dose of was given and the glucose level went up to 60 mg/dl. Resident #6 remained hospitalized until .

A review of Resident #6's record revealed that there was no progress note on explaining Resident #6's significant change that resulted in medical attention.

In an interview on at 12:24 PM when asked what happened to Resident #6, the Administrator stated, "I don't know why Resident #6's sugar lowered; it was part of the change in condition.

A review of Resident #6's health assessment dated showed medical history and diagnoses: , chronic kidney , , major , , dyslipidemia, D Deficiency, . Physical or sensory limitations: poor balance, difficulty walking, risk. Resident was alert and oriented time, place and person and followed instructions. Special precautions showed (low sugar level). Resident needed supervision for all activities of daily living except dressing and toileting which could be done independent. Resident's special diet precautions showed: no concentrated sweets. Resident's needs

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can be met in an ALF. Resident needed assistance with self-administration of medications.

In an phone interview on at 2:52 PM, the Administrator revealed that she called 911 for Resident #6 because the resident showed signs of low sugar. Resident #6 consumed a Glucerna shake before checking the sugar in the morning. The Administrator reiterated that the resident had only received one can og Glucerna that morning, and had received no other food.

In an interview on at 10:15 AM, the Administrator revealed, regarding Resident #4 that there was a resident with , but that the home health agency had not admitted the resident yet. The administrator called the home health the night before ( ).

A review of the facility's admission and discharge log revealed that Resident #4's admission date was on .

A review of Resident #4's record revealed that was a prescription for dated for a sliding scale for lispro ( ) 100 units/ml solution before meals and at bedtimes:

- Below 149 : give 0 units
- 150-190: give 2 units
- 200-249: give 3 units
- 250- 299: give 4 units
- 300-349: give 5 units
- 350-399: give 6 units
- 400-449: give 8 units
- Above 450: give 10 units and call MD.

There was no documentation that anyone was checking Resident #4's sugar level or injecting the .

The available in the facility was mix . available in the facility did not match with the sliding scale in record. There was no documentation that the resident received the and .

Review of Resident #4's MORs revealed Mix - inject , twice a day according to sliding scale. It was not initialed on any day by anyone between and . There was no note that home health agency or the registered nurse from the facility was checking the sugar.

A review of the personnel record showed that the Administrator was a registered nurse. In an interview on at 2:17 PM, the Administrator stated, "Can I check Resident #4's sugar level? They

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said that I can't use my nurse's license in the ALF?"

In an interview on at 8:46 AM Administrator stated, "I checked Resident #4 sugar level every day twice a day and administered the twice a day. I said no because I did not want to get my registered nurse license in trouble. I administered 6 units twice a day."

Class II

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 seven sampled residents with self-administration of medications (Resident #1).

Finding included:

Observation on at 10:48 AM revealed that there was a small clear cup with medicines inside (three tables and one capsules) prepared in advance inside the medicine box for Resident #1.

In an interview on at 10:49 AM, the Administrator stated, "Resident #1 just woke up."

In an interview on at 10:50 AM Staff B stated, "I don't think the Resident needs to see when I prepare the medicines. Resident #1 woke up late and I brought medicines to the ."

A review of Staff B's personnel record revealed that Staff B did not complete the initial 4 hour training on providing assistance with self-administered medications and safe medication practices in an assisted living facility.

Class III

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

Based on record review and interview, the Assisted Living Facility failed to have a Medication Observation Record (MORs) for three of seven sampled residents (#1, #2 and #4) .

Findings included:

A review of Resident #1's MORs revealed that there was no medication sheet for that resident for the

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month of 2017.

In an interview on at 10:46 AM Administrator stated, "Staff B said that they did not send the med sheet."

A review of Resident #2's MORs revealed that none of Resident #2's medicines had a schedule time. Medicines were:
- 100 mg tablets- take one tablet by mouth daily.
- 325 mg tablet- take one tablet by mouth daily.
- 5 mg tablet- take one tablet by mouth daily.
- 0.1 mg tablet- take one tablet by mouth daily if more than
- 20 mg tablet- take one tablet every other day.
- 10 gm/15 ml solution- take 30 ml as needed.
- 500 mg tablet- take one tablet by twice a day as needed.
- DR 20 mg Cap- take one capsule by mouth daily.
- 50 mg tab- take one tablet by mouth daily
- 10 mg tablet- take one tablet by mouth at bedtime.

Further review of the MOR showed that Resident #2's medication was documented as given on and but not on .

A review of Resident #2's showed on was , on was , on was ; result for was missing.

A review of Resident #2's MORs revealed that 50 mg tablet was not initialed as given on and .

In an interview on at 11:10 AM, the Administrator stated, "there are too many little details."

A review of facility's admission and discharge log revealed that Resident #4 admission date was on .

A review of Resident #4's MORs revealed that showed:
- Calcitrol 0.5 mcg capsule- take two capsules together on Mondays, Wednesdays and ... (order incomplete)- it was initialed as given on and at 8 AM
- Carvidopa/ 25-100 tab- take one tablet by mouth by mouth three times a day.- it was initialed as given just at 8 am and 8 PM. 2 PM dose was not initialed as given; it was not initialed on

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at 2 PM and 8 PM and on at 8 AM.
- 60 mg tab- take one tablet by mouth by mouth three times a day.- it was initialed as given just at 8 am and 8 PM. - 2 PM dose was not initialed as given it was not initialed on at 2 PM and 8 PM and on at 8 AM.
- 40 mg tablet- take one tablet by mouth once a day; it was not initialed on at 8 AM.
- opth 0.5% sol- instill one drop in both eyes at bedtime; it was not initialed on at 8 PM.
- 500 mg tab- take two tablets together twice a day- it was not initialed on at 8 PM and on at 8 AM.
- 25 mcg tablet- take one tablet once a day 30 minutes before ... (order incomplete)- it was not initialed on at 8 AM.
- Mix - inject twice a day according to sliding scale- it was not initialed any day for any one one. There was no note that home health agency nor registered nurse from the facility was doing it.
- 60 mg tablet- take one tablet once a day- it was not initialed on at 8 AM.
- Rena Vite tablet- take one tablet once a day- it was not initialed on at 8 AM.
- 80-4.5 mcg inhaler- inhale two puff by mouth twice a day- was not initialed at all on , , and .

In an interview on at 8:31 AM, the Administrator revealed that Staff B forgot to sign the 2 PM dose for Carvidopa/ , 25-100 tab and 60 mg tab doses.

Class III

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

Based on record review, and interview, the Assisted Living Facility failed to obtain clarification order for a medication ordered as needed or notify the doctor of changes that needed with the orders for one (#2) out of seven sampled residents.

Findings included:

A review of Resident #2's Medication Observation Records (MORs) revealed that there was an order for , 500 mg tablet- take one tablet by twice a day as needed and for 10 gm/15 ml solution- take 30 ml as needed. There was no documentation about the conditions under which the as needed medications should be taken or at what time.

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In an interview on at 11:10 AM Administrator stated, "there are too many little details."

Class III

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

Based on observations, record reviews, and interviews, the Assisted Living Facility (ALF)'s Administrator failed to ensure that residents had qualified and trained staff to provide resident care and meet the residents' needs (Staff B). Facility's Administrator failed to submit an one day adverse incident report to the Agency after the elopement of one (Resident # 6) out of seven sampled residents. Resident did not have accurate health assessment for one (#2) out of seven sampled residents. Administrator failed to ensure that Staff who provide direct care to residents, who have not taken the core training program, received a minimum of 1 hour in-service training within 30 days of employment that covers resident rights in an assisted living facility and recognizing and reporting resident , neglect, and , (Staff B).

Findings included:

1. Review of Resident #1's MORs revealed that there was no medication sheet for that resident for the month of 2017.

In an interview on at 10:46 AM Administrator stated, "Staff B said that they did not send the med sheet."

Observation on at 10:48 AM revealed that there was a small clear cup with medicines inside (three tables and one capsules) prepared in advance inside the medicine box for Resident #1.

In an interview on at 10:49 AM Administrator stated, "Resident just woke up."

In an interview on at 10:50 AM Staff B stated, "I don't think Resident needs to see when I prepare the medicines. Resident #1 woke up late and I brought medicines to the ."

A review of Staff B's personnel record revealed that Staff B did not complete the initial 4 hour training on providing assistance with self-administered medications and safe medication practices in an assisted living facility.

In an interview on at 2:34 PM Administrator stated, "I have it but it is not here" turned to Staff B and stated "Call your school they did not give your medication training."

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2. A Review of Resident #6's hospital record showed that on when rescue arrived to ALF, the Resident's sugar level was 20 mg/dl (really low). They administered glucose and and glucose level went up to 40 mg/dl. Second dose of was given and glucose level went up to 60 mg/dl. Resident #6 arrived to emergency department at 1:22 PM and revealed that did not not eat breakfast that morning. Resident #6 remained hospitalized until .

In an interview on at 8:34 AM Administrator stated, "Does the facility need to file an incident report for that?"

3. A Review of Resident #2's record showed that admission date was . Health assessment (AHCA form 1823) completed on showed medical history and diagnoses: history of ( ), , Mixed , , Chronic , Chronic Kidney , Mild , . Nursing/ treatment/ , service requirement: hospice will provide care for this patient when back in the ALF. Resident needed supervision for eating, assistance for ambulation, dressing, self-care( ), toileting and transferring, but needed total care for bathing. Resident's special diet precautions showed: puree diet. It stated that the Resident's needs can be met in an ALF. It did not show if Resident needed help or not taking the medicines. Further review of the record showed that Resident #2's diet changed from puree to regular on . There was a doctor order in Resident #6's record dated from hospice for 2-3 liter per minutes as need via nasal cannula, full bed rails, diet: regular as tolerated (diet).

In an interview on at 8:33 AM Administrator revealed that Staff assisted Resident #2 with self-administration of medication.

4. Review of Staff B's personnel record showed that hire date was on . There was no proof of completed resident rights in an assisted living facility and recognizing and reporting resident , neglect, and , training.

In an interview on at 8:36 AM Administrator stated, "Staff B went back to school and came back with the HHA paper."

Class III

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

Based on observation and record review, the Assisted Living Facility failed to provide a written work

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schedule that reflected its 24-hour staffing pattern for a given time period.

Findings included:

Observation on at 10 AM revealed that Administrator was on duty.

Observation on at 10:25 AM revealed that Staff B was on duty.

A review of the staffing pattern for the week of 11/05 to showed the Administrator was on duty on and . Staff C was on duty on , , and . Staff B was on duty 11/05, , and .

In an interview on at 2:04 PM Administrator stated, "I meant that the person is working and slept over from 7 AM to next day 7 AM."

Class III

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

Based on record review and interview, the Assisted Living Facility failed to maintain the employment status of all employees on its roster within the background screening clearinghouse database.

Findings included:

A review of the Background Screening Clearinghouse Database for providers showed that the Assisted Living Facility's employee roster was empty.

In an interview via telephone on at 2:48 PM, the Administrator stated, "I have not done it yet; I thought it was something new and I have more time to do it."

Unclassified