STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965870	01/19/2018
NAME OF PROVIDER OR SUPPLIER **1 ZOURCE LIVING CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1401 NE 176 STREET** **MIAMI, FL 33162**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

A Biennial Survey was conducted on through at 1 Zource Living Care (license # 10183). The following deficiencies were identified at the time of survey:

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on observation, record review, and interview, the facility failed to have a completed Health Assessment on file for one out of four sampled residents (Resident #1).

Findings included:

On at 10:28 AM, Resident #1 was observed walking from the backyard to the assistance or a walker, holding the wall sometimes with his hands.

A review of the Health Assessment dated , showed diagnoses of " , , , , and , " and for sensory limitations "patient is ."
However, The new Health Assessment dated did not state that Resident #1 was .

During Interview at 10:48 AM, Staff C stated "Yes, Resident #1 is , maybe they forgot to write it on the new Health Assessment."

During an interview on at 3:39 PM Resident #1 stated ", I can't see, but I can write my name, I even sign my ID; I don't need no more help I manage to live this way, I don't want any guardian, I don't have any family."

Class III

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

Based on record review and interview, the facility failed to ensure the appropriateness of continued residency for one of six sampled residents (# 6). The resident was was aggressive towards facility staff, disturbing the peace in the neighborhood, and away from the facility several times without staff knowledge of his whereabouts. The last time, after being missing for four days, the resident was found and hospitalized by police.

Findings included:

A review of Resident #6's record revealed the resident was admitted on and discharge on

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. The last health assessment dated showed a diagnosis of Type 2 (II). Resident #6 was not identified as an elopement risk on the assessment.

On at 1:30 PM Staff C stated, "I went on vacation and when I came back. The neighbors contacted me and told me about him being loud. A lot of the neighbors were complaining about him. An officer came here because of that. I notice he was acting different. He would not sleep at night. He would go outside and talk so loud. He would be aggressive and get angry. I was doing his laundry and found his medications in the pockets. One day I was doing the laundry, I found two scissors and a broken mirror in his pocket. I called the manager, the social worker to let them know what was going on with him. The next day he went to the doctor and when came back I went outside he was lying down and talking loud. The next day he left and he did not log out. He never came back. I informed the Administrator and he told me to call the police. When the officer came I told him everything."

A review of the progress notes for Resident #6 dated showed: "At around 2:30 PM found 3 tablets in Resident #6's pocket. 2 tabs & 1 , . I found it prior to loading of his soiled clothes to washing machine. This incident already reported to Administrator of this ALF." The record also stated "Resident #6 came back at around 8:00 or 9:00 PM. The caregiver caught his attention regarding the police here that he needs to observe and follow the given rules & regulations."

A review of the progress notes in Resident #6's file dated showed: "Police came to the facility to conduct investigation regarding Resident #6. One of his medication was discontinued by the doctor. The administrator confront resident about facility rules and regulations and that he would be dismissed from facility if he did not follow them."

A review of the progress notes in Resident #6's file dated showed: "The Resident went to Miami Beach and then contacted the caregiver that he will not return to the facility and will stay with friends. The caregiver informed the Administrator. The Administrator advised caregiver to inform resident to contact and inform case manager of plans." The record also stated: " Resident did not come back to the facility. The caregiver called him and he could not be reached and then informed the Administrator. She was then told to call the case manager and she left a message."

A review of the progress notes in Resident #6's file dated showed: "Caregiver attempted contact 9:00 AM to 10:00 AM, but was not able to reach Resident #6. Resident #6, around 3:00 PM, was able to contact resident where he told her he would return to facility in the afternoon. 8:00 PM resident never returned to the facility and the caregiver informed the Administrator." There was no documentation that a police report was filed. A review of the adverse incident report atabase showed that a report was never filed for this elopement and there was no documentation of follow-up by the Administrator with

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Resident #6's physician.

A review of the progress notes in Resident #6's file dated showed: "On this day, the Staff C called up the psych manager regarding Resident 6's medicines. The manager said Resident #6 refused to go to Dr.'s appointment saying that it's not ordered by the court. Because of noncompliance with these medicines. Resident #6 displayed aggressive behavior. He is mentally unstable, always yelling, cursing and talking to himself loudly. He never sleeps, rather talking so loud that makes other residents disturbed." There was no documentation of further action taken to assist the resident.

A review of the progress notes in Resident #6's file dated showed: "The caregiver sorted out the soiled clothes/ pants of Resident #6. To my surprise I touched something sharp inside his khaki pants, a broken mirror glass and scissors inside the pocket. This matter was brought to the knowledge of the administrator". There was no documentation of intervention with the resident, or notification being given to the resident's health care provider.

A review of the progress notes in Resident #6's file dated showed: "Resident #6 went to Miami South as shown to our log in/out book on 6 at 7:30 PM and came back around 12:00 AM on the morning of Tuesday. He did not use the doorbell, but rather slept outside the house." A review of the progress notes in Resident #6's file dated showed a note saying, "At around 8:00 AM after breakfast Resident #6 once again left the facility without logging out. He didn't come home. No call that he will be late coming home till the following day. No Resident #6 showing up. Reported to Administrator." There was no documentation of any intervention.

A review of the progress notes in Resident #6's file dated showed: "At 10:00 PM-Wednesday the caregiver as per instruction of the Administrator to call a non-emergency police that Resident #6 is missing that very same night. The officer came in and took all Resident #6's information. The officer gave me the case number. Because of non compliance to pysch meds the other police officer suggested to bring this matter back to court and ask for Ex-parte court order." A review of the progress notes in Resident #6's file dated showed: "3:30 PM The caregiver called-up the social worker. Unfortunately the social worker left the office already. Left a message to other lady, regarding the ex-parte court order."

A review of the progress notes in Resident #6's file dated showed: Yesterday, at around 2:00 PM received a call from the Administrator informing that Resident #6 was found by the police officer walking on the street. Resident #6 was directly bought to hospital for further management 'Psych'".

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Class II

0026 - Resident Care - Social & Leisure Activities - 58A-5.0182(2) FAC

Based on observation, record review, and interview the facility failed to encourage the residents to participate in social, recreational, educational and other activities within the facility and the community.

Findings included:

On observed no activities from 9 am until exit at 5:00 PM. The residents were observed in their or sitting in the backyard.

A review of the undated activity calendar posted showed the following schedule: 7:30 am - 8:30 am meditation, watch TV, 8:30-10 am smoking, bath, walking at the porch, 12:30 PM-2:30 PM watch TV, mind game, Q&A, 3 PM-4:30 PM watch TV, play games or Q&A, smoking.

During an interview on at 2:28 PM 02:28, Resident #3 stated "There is no activities, I just watch TV."

During an interview on at 2:44 PM, Resident #5 stated "They should keep more books here to read. There is nothing else to do."

During the exit interview Staff C stated "we do activities with the residents, Resident #5 plays piano, Resident #3 stretches in the morning."

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on record review and interview and failed to conduct two elopement drills annually.

Findings included:

A review of the facility's drill records showed the drills were completed on , . There were no drills completed in 2016 and one drill was completed on .

Interview on at 4:30 PM with the Administrator acknowledged the elopement drills were not done in 2016 and that one drill was conducted between , and 2017.

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Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the facility failed to have a written statement documenting a negative examination from a health care provider and documenting freedom from signs or symptoms of communicable for one out of four sampled staff (Staff B).

Findings included:

A review of Staff B' s personnel file on revealed that there was no documentation of a negative test or a statement of freedom from signs or symptoms of communicable .

During the exit interview on at 4:34 PM, Staff A acknowledged that the statement was not in Staff B's personnel file.

Class III

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

Based on record review, and interview, the facility failed provide documentation that one out of four sampled staff received three hours training on Activities of Daily Living (ADL) and Behavioral needs (Staff D) .

Findings included:

Record reviewed revealed that Staff D, hired on , had documentation of one and a half hours ADL's training in file dated .

During the exit interview on at 4:34 PM Staff A acknowledged that Staff D did not complete three hours of training in this area.

Class III

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

Based on observation, record review, and interview, the facility failed to provide documentation that four sampled staff completed the initial 4 hours and a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted

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living facility (Staff A, B,C, and D).

Findings included:

On at 12:53 PM, Staff C was observed assisting with self-administration of medication for Resident #1 and Resident #4.

A review of the Medication observation record revealed that Staff C signed after assisting the residents with self-administration.

During an interview on at 02:44 PM Resident #5 stated "Staff C hands the medication to me in a cup and I take it with a cup of water."

During and interview on at 03:55 PM Staff D stated "No, Staff C assists with the medication, but I put eye drops for Resident #1, one in the morning and one in the afternoon."

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review and interview, the facility failed to ensure that Staff D had an understanding of the policy and procedures regarding ( ).

Findings included:

A review of personnel files revealed Staff D completed two hours of training on .

During an interview on at 3:51 PM Staff D stated " means in case of emergency we do ."

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview, the facility failed to complete and submit 1 day initial adverse incident report and 15 day full incident report to the agency for one out of six sampled residents (#5).

Findings included:

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A review of Resident #5's demographic sheet revealed he was admitted to the facility on .

A review of the Progress Notes documented Resident #5 left the facility on and later that afternoon called to advise he was spending the evening with friends and he did not return until at 8 PM according to the facility's In/ Out log. On at 1:45 PM, the Administrator stated, "He had permission to visit his friend."

A review of Resident #5's record showed that on the facility called the police to report the resident missing. Resident #5 was found by the police on . The facility did not submit a 1 day initial and 15 day full adverse incident report.

On at 3:58 PM, the Administrator stated, "I was trying to do it. I could not log into the system. It was the weekend."

Class III

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

Based on record review and interview, the facility failed to maintain a signed Attestation of Compliance With Background screening (BGS) on file for all sampled staff (Staff A, B, C, and D).

Findings included:

A review of the personnel files revealed that Staff A, B, C and D did not have a signed attestation of BGS in their file.

During the exit interview at 4:34 PM, Staff A stated "I don't know what it is, show me, I will make sure that I put in the all the files."

Class II