STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967094	R 01/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERE'S SENIOR CARE	**17950 SW 155 COURT** **MIAMI, FL 33187**

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

0000 - Initial Comments

A Standard Biennial Revisit Survey was conducted on 01/03/18 and concluded on 01/10/18. Tere's Senior Care (License #11198) with Limited Mental Health component had the following deficiencies found at the time of the survey:

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

Based on observations, record review, and interview, the facility failed to maintain a written record for one out of five sampled residents who was transferred to the hospital after a with injury (Resident #2).

Findings included:

On at 8:28 A.M., observed Resident #2 transferring to the dining a cane. The resident was wearing a on her left arm. Resident #2 stated, "I few days ago in my . I slid down, my reaction was to I put my hand on the wall to prevent a big . I my wrist."

A review of Resident #2's record revealed the facility did not have any documentation in the file regarding a . A health assessment a health assessment dated 11/ showed the following diagnoses: Long Term use of Anticoagulated; , ( ); , ( ). Resident #2 had precautions and she needed assistance with all activities of daily living (ADLs).

Hospital record review on for Resident #2 revealed the resident was transferred to the hospital via ambulance on . The reason of admission was a resulting in injury for 6 hours. Hospital admission note dated at 9:26 EST showed that female complaining of left wrist pain and . Resident #2 slipped and at home and she will go for surgery today. The X-ray of wrist completed with a minimum of 3 views impression showed of the .

During an interview on at 10:01 A.M., the Administrator stated Resident #2 slipped and hit her left hand with the wall in the morning around 6:30 A.M., The administrator looked at the medication observation records (MORs) and stated the incident occurred on . And she was discharge from the hospital on . The Administrator stated, "I called the physician and I requested X-ray, they sent the Mobil X-ray that arrived at 8:30 A.M., they told me to take Resident #2 to the hospital because she needed a ."

Class III

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

Based on observation, record review, and interview, the facility failed to assist residents with self-administration of medications one hour after the scheduled time per pharmacy practices for two out of six sampled residents. (#1, 2 and 4).

Finding included:

On at 9:03 A.M. observed the Administrator assisting Resident #2 with self-administration of medications. The medications were: 10 mg, .5 mg, sod 1 mg, 40 mg, 10 mg.

Further observations on at 9:07 A.M. found the Administrator was assisting Resident #4 with self-administration of medications. The medications were: 2 mg, 10 mg, 5 mg, 500 mg, 20 mg, 325, 2 mg, 2 mg, and 500 mg.

More medication pass observation on at 9:24 A.M. found the Administrator went to Resident #1 assist him with self-administration of medications. The medications were: 40 mg, 2.5 mg, 25 mg, 0.2 mg, 80 mg, 100 mg, 125 mg, 81 mg, and multiple .

Review of the medication observation records (MORs) for Resident's #1, #2 and #4 and it revealed the medications were scheduled for 7:00 A.M.

On at 9:10 A.M. the Administrator stated, "I assisted residents with their medication at 9:00 A.M. even though that a doctor order medications at 7:00 A.M., because it is very and they are getting up from bed late."

Uncorrected Class III

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

Based on observation, record review, and interview, the facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern.

Findings included:

Observation on at 8:20 A.M. revealed Staff E was alone in the facility taking care of five

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residents. She stated "I'm going to contact the administrator." Further observation on /1/8 at 8:40 A.M. found the Administrator arrived to the facility.

Review of facility's record showed the staff schedule posted in bulletin board was for 2017.

The Administrator stated on at 8:56 A.M., the staffing scheduled for , 2018 was behind the 2017 scheduled. The , 2018 scheduled reflected that Administrator was scheduled to work from 7:00 A.M. to 7:00 P.M., and Staff D from 7:00 P.M. to 7:00 A.M.

On at 8:56 A.M., the Administrator acknowledged that Staff E name was not listed on the schedules.

Record review revealed the facility did not have a personnel record for Staff E.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on observation, interview and record review, the facility failed to have personnel records for one out of five sampled staff (Staff E).

Findings included:

Observation on at 8:20 A.M. revealed Staff E was alone in the facility taking care of five residents.

On at 9:12 A.M. Staff E stated, "I'm been working here since ".

On at 9:14 A.M. the Administrator stated, "Staff E help me out here in the facility with the residents ADLs, cleaning cooking, bathe, dressing.

Record review showed the facility did not have a staff record for Staff E.

Class III

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

Based on observation, interview and record review, the facility failed to file an adverse incident report one day and 15 days for one out of five sampled residents. Resident #2 and sustained a wrist

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that required surgery.

Findings included:

On at 8:28 A.M., observed Resident #2 transferring to the dining a cane. The resident was wearing a on her left arm. Resident #2 stated, "I few days ago in my . I slid down, my reaction was to I put my hand on the wall to prevent a big . I my wrist."

Hospital record review on for Resident #2 revealed the resident was transferred to the hospital via ambulance on . The reason of admission was a resulting in injury for 6 hours. Hospital admission note dated at 9:26 EST showed that female complaining of left wrist pain and . Resident #2 slipped and at home and she will go for surgery today. The X-ray of wrist completed with a minimum of 3 views impression showed of the .

During an interview on at 10:01 A.M., the Administrator stated Resident #2 slipped and hit her left hand with the wall in the morning around 6:30 A.M., The administrator looked at the medication observation records (MORs) and stated the incident occurred on . And she was discharge from the hospital on . The Administrator stated, "I called the physician and I requested X-ray, they sent the Mobil X-ray that arrived at 8:30 A.M., they told me to take Resident #2 to the hospital because she needed a ."

On at 8:53 A.M. the Administrator stated that she did not file and incident report with the Agency.

Class III

N276 - LNS - Nursing Services - 58A-5.031(1) FAC

Based on observation, interview, and record review, the facility admitted one out of five sampled residents who required limited nursing services to care for and (Resident #2). Resident #2 and sustained a wrist that required a .

Findings included:

On at 8:28 A.M. observed Resident #2 transferring to the dining a cane. The resident was wearing a on her left arm. Resident #2 stated, "I few days ago in my . I slid down, my reaction was to I put my hand on the wall to prevent a big . I my wrist."

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A review of Resident #2's record revealed the facility did not have any documentation in the file regarding a . A health assessment a health assessment dated 11/ showed the following diagnoses: Long Term use of Anticoagulated; , ( ); , ( ). Resident #2 had precautions and she needed assistance with all activities of daily living (ADLs).

Hospital record review on for Resident #2 revealed the resident was transferred to the hospital via ambulance on . The reason of admission was a resulting in injury for 6 hours. Hospital admission note dated at 9:26 EST showed that female complaining of left wrist pain and . Resident #2 slipped and at home and she will go for surgery today. The X-ray of wrist completed with a minimum of 3 views impression showed of the .

During an interview on at 10:01 A.M., the Administrator stated Resident #2 slipped and hit her left hand with the wall in the morning around 6:30 A.M., The administrator looked at the medication observation records (MORs) and stated the incident occurred on . And she was discharge from the hospital on . The Administrator stated, "I called the physician and I requested X-ray, they sent the Mobil X-ray that arrived at 8:30 A.M., they told me to take Resident #2 to the hospital because she needed a ."

Facility record showed that facility did not have limited nursing services, per administrator "I do not have a nurse that supervises the ". Resident #2 record did not have any documentation.

Class III

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Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on observation, record review, and interview, the facility failed to have an eligible level II background screening for one out of five sampled staff prior providing direct care and services to residents (Staff E).

Findings included:

Observation on at 8:20 A.M. revealed Staff E was alone in the facility taking care of five residents. During the survey observed Staff E preparing and serving breakfast to the residents.

On at 8:23 A.M. Resident #4 stated, "I'm living here for few months with my dad, Staff E does a lot of thing for us."

On at 9:12 A.M. Staff E stated, "I'm been working here since ".

On at 9:14 A.M. the Administrator stated, "Staff E help me out here in the facility with the residents ADLs, cleaning cooking, bathe, dressing.

Record review showed the facility did not have a staff record for Staff E with an eligible level II background screening.

Unclassified