STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965650	**12/19/2017**
NAME OF PROVIDER OR SUPPLIER **RES-CARE PREMIER**	STREET ADDRESS, CITY, STATE, ZIP CODE **12981 SW 52ND STREET** **FORT LAUDERDALE, FL 33330**	

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

0000 - Initial Comments

A Complaint Investigation, CCR #2017014816, was conducted on - and at Res-Care Premiere, Inc, License #10009. The facility had deficiencies at the time of the investigation.

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

Based on interview and record review, it was determined that the facility failed to ensure that a resident was reassessed by his/her healthcare provider and results documented on the Resident Health Assessment Form (AHCA form 1823) after a resident exhibited significant health changes, for 1 out of 4 sampled residents' records reviewed (Resident #2).

The findings include:

Record review revealed Resident #2 was admitted into the ALF by court order on . According to 1823 (Resident Health Assessment) Resident #2 suffered a in 2006 and has ongoing . 1823 also state Resident #2 is pleasant, calm, , , follow all commands, poor insight, poor judgement and poor safety awareness. Review of Resident #2 file revealed no further health assessments. However, review of the residents observation notes and progress notes revealed the following.

A. On - Resident #2 became irate after having a conversation with his mother and advise staff that he was leaving the facility. The Administrator attempted to counsel him into a more effective way to handle his anger. Resident #2 suddenly punch the Administrator in his shoulder. The administrator continued to follow him outside attempting to have him return to the facility, Resident #2 attempted to punch the Administrator for the second time. After several unsuccessful attempts to calm him down, Police was called for assistance and brought the resident back home.

B. On - Resident #2 was screaming profane language throughout the facility. Resident #2 proceeded to pick up a biohazard container and a cordless phone slamming them on the floor close to where Resident #3 was sitting in the living . Resident #2 then turned to Resident #3 and asked, "What are you talking about bruh". Resident #2 hit Resident #3 in the chest and grabbed his shirt with his left arm. As a result, of the incident Resident #3 suffered a at the top of his right arm.

C. On - Resident #2 was refusing to take his medicine; the resident became very agitated as the time went by. Administrator attempted to keep the resident calm and redirect him several times. Resident #2 began swinging his fist striking his case manager in the throat. The case manager told police his throat was hurting from the strike but did not wish to prosecute.

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D. On at 1:30 PM during several confidential interviews it was also revealed that Resident #2 had stolen Staff B vehicle in , 2016 (Exact date unknown) and the vehicle was recovered in Homestead, FL. Resident #2 was taken to jail and charges were later dropped. Interviews also revealed that Resident #2 has previously thrown cordless phones and chairs at staff and resident when irate.

E. On at 2:30 PM confidential interviews also revealed that resident#2 continuously steals other residents personal belongings and initiate a fight with all new residents. Resident #2 walks around the facility stating "I have to whoop his [....] to see what he's about". Interviews also revealed that Resident #2 has provoking walked closely into both staff and residents face with profane language.

F. Facility records revealed Resident #2 bumped into Resident #4 and began using profane language to the resident. Resident#2 shoved himself in Resident #4 face. Both residents had to be separated by staff as they were very upset and staff suspected they were going to start fighting. Resident #4 expressed his grievance that he has only been living at the facility for one month and Resident #2 continues to provoke him. Resident #4 stated he does not want to go to jail and he is afraid if he hit him in self-defense he will be taken to jail.

G. On at 12:00 PM, a confidential interview revealed that on Resident #2 took a paper towel out of the kitchen and lit the paper towel on fire when the staff refused to give him another pack of cigarettes. Resident #2 has a signed a agreement to only have one pack of cigarettes a day. When the staff member advised him to put out the fire he locked himself in the shouted he is going to this place down. The staff member called 911. 911 responded to the residence. The staff member went outside and spoke to the police and then informed Resident #2 that the cops wanted to speak with him outside. After speaking with the cops he came back inside calm and locked himself in his . Resident #2 reported no concerns regarding the facility.

During an interview with the Administrator on at 11:10 AM, he revealed he spoke with the staff member on and she never informed him of Resident #2 lighting a fire in the house. He also stated that when he spoke to Resident #2 on , he never informed him of any problems occurring at the facility. The Administrator was questioned regarding the numerous incidents that have occurred during the course of the last two years with Resident #2 aggressive behavior against himself, residents and direct care staff. The Administrator stated he has good days and bad days, usually when he does not get a cigarette is when he really get agitated. The Administrator admitted that the doctor has not been advised of reoccurring events of aggressiveness but his caseworker has been notified of the incidents. The Administrator acknowledged that the resident has not been reassessed and/or evaluated to ensure that the resident met the criteria for continued residency and that the facility could met his care

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needs (including his aggressive behavior).

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on interview and record review, it was determine that the facility failed to report medication concerns (including resident refusal) to the resident's health care provider, for 1 out of 3 sampled residents (Resident #2) .

The findings include:

Based on record review of Resident #2 MOR for the month of 2017, the following medications were ordered by the doctor:
a) 81 MG TAB-Take by mouth once a day for prevention
b) Levitiracetam 100 MG Tabs - Take two tablets by mouth twice daily for
c) Tab 10 MG -Take one tab by mouth twice daily for muscle spasms
d) Tab 200 MG - One tab by mouth twice daily as a supplement
e) INJ Flextouch - Inject 23 units at bedtime for
f) Divalprorol 500 mg Tab - Take one by mouth every 12 hours for

Record review revealed Divalprorol 500 mg tab was ordered by the Emergency on . A request was made to review 2017 MOR and the Administrator informed the surveyor that MOR could not be located anywhere in the facility after numerous attempts to find it. Further review revealed that Resident #2 has been refusing the prescribed medication from - stating the medication make him feel and give him a .

An interview conducted with the Administrator on at 12:45 PM reveal that his staff had informed him of the daily refusal of Divalprorol 500 MG Tab and that he failed to ensure the doctor was notified and/ or to have an appointment made for Resident #2 to see the doctor. The Administrator stated that he had informed his case worker and the case worker failed to inform Resident #2's doctor as the case worker is responsible to make all arrangements for Resident#2 healthcare needs.

An interview with Resident #2 on at 1:15 PM revealed that he only took the medication for

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two days on and and both days it gave him a and he also had several , spells. He stated that he informed the staff members about the way the medication made him feel and they try to offer it to him every day.

Class III

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

Based on record review and interview, it was determined that the Administrator failed to ensure that the facility was maintained in a safe manner for all residents. As evidence, the facility failed to address Resident #2's aggressive behavior towards residents and staff .

The findings include:

Based on interview and record review it was determine that the facility administrator had knowledge of events occurring in the facility during the year between mid 2015 to 2017 regarding Resident #2 behavior that jeopardize the resident safety, other residents that reside in the facility and staff members.

Record review reveal numerous police reports showing the behavior of Resident #2. Review of the resident record and incident report confirm the resident aggressive behavior. The facility Administrator implemented no steps or procedures to prevent the reoccurrence of violent behavior exhibited by Resident #2. The Administrator also failed to provide documentation reaching out to Resident#2 doctor regarding the significant behavioral change.

During an interview with the Administrator at 12:59pm, a request was made for documentation or evidence of steps implemented to prevent reoccurrence or notification. However, the Administrator was unable to provide any documentation illustrating facility intervention. Therefore contributing to the increase rise of the aggressive behavior exhibited by Resident #2.

Reference A 0010 for additional findings.

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Class III