STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967495	**02/13/2018**
NAME OF PROVIDER OR SUPPLIER **LEISURE CITY HOME CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **14785 COOLIDGE LANE** **HOMESTEAD, FL 33033**	

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

0000 - Initial Comments

A standard biennial survey was conducted from , 2018. Leisure City Home Care with limited mental health component and license #11541 had the following deficiencies identified at the time of the survey:

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

Based on record review and interview, the Assisted Living Facility failed to offer and provide social, recreational or educational, and other activities to the residents.

Findings included:

The activity calendar for , 2018 posted on the bulletin board. It showed Exercise/ Walking. The activity calendar did not show the amounts of hours spend on activities.

In an interview on at 8:32 AM Resident #5 revealed that facility did not provide activities.
In an interview on at 8:36 AM Resident #2 revealed that facility did not provide activities.
In an interview on at 9:56 AM Resident #1 revealed that he watched TV and went to the front porch to smoke.
In an interview on at 11:50 AM Resident #4 revealed that he watched TV in his .

In an interview on at 2:48 PM Administrator revealed that residents liked to watch soap operas.

Class III

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

Based on observation and record review, the Assisted Living Facility failed to maintain the minimum staff of 212 hours hours per week for 6 residents. The facility's staff hours hours per week were 163 hours.

Finding included:

Observation on at 8:20 AM revealed that Staff C and D were on duty. Residents #1, #2, #3, #4, #5 and #6 were in the facility.

Review of Staff Schedule for , 2018 showed that Staff C worked 50 hours per week and Staff D

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worked 113 hours per week. Staff C was OFF on Saturdays and Sundays and worked from Monday to Friday from 7 AM to 5 PM. Staff D worked from Monday to Friday from 5 PM to 8 AM; Saturdays and Sunday worked 24 hours each days. Staff C and D worked a weekly total hours of 163 hours.

Class III

0125 - Fiscal - Surety Bonds - 429.27(2) FS; 58A-5.021(3) FAC

Based on record review and interview, the Assisted Living Facility provider failed to have a surety bond in place. The facility served as representative payee for one out of seven sampled residents (#4) .

Findings included.

In an interview on at 1:53 PM, the Administrator revealed that facility received direct deposit from the social security office from Resident #4.

A review of facility records revealed that there was no documentation that the facility had a surety bond .

Class III

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

Based on record review and interview, the Assisted Living Facility failed to have asigned Attestation in the employee's personnel file for three out of four sampled staff (Manager, Staff C and D).

Findings included:

Review of Manager's personnel file revealed that hire date was on and there was no signed Attestation of Compliance with Background Screening Requirement.

Review of Staff C's personnel file revealed that hire date was on and there was no signed Attestation of Compliance with Background Screening Requirement.

Review of Staff D's personnel file revealed that hire date was on and there was no signed Attestation of Compliance with Background Screening Requirement.

In an interview on at 2:52 PM Administrator revealed that did not realize that the attestation of compliance with background screening requirements was missing for those staff.

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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 Assisted Living Facility failed to submit an adverse incident report within one business day after the incident and within 15 days of the incident to AHCA when one out of seven sampled resident's condition required him/her to be transported to a unit providing more acute care due to a . . (#7).

Findings included:

In an interview on . . . . . at 12:09 PM, the Administrator revealed that Resident #7, who received hospice services, . . The Resident in the facility and hit his/her head. At 12: 11 PM, the Administrator revealed that s/he did not remember completing an adverse incident report for that . .

A review of Resident #7's record revealed that the admission date was on . . . . . . The Health assessment (AHCA form 1823) completed on showed that the Resident needed supervision for all activities of daily living and needed . precautions. The facility documented in the progress notes for the Resident:
- On . . . . . , the resident . because s/he refused to use the walker. The resident's son and daughter-in-law were present, and called 911. The resident went to the hospital, where s/he was evaluated and later discharged. The family brought the Resident back to the facility. The resident hit the left upper front side of his/her head.
- On . . . . . at 8:30 PM, the resident got up of bed without using the walker after s/he took the medicines. The resident . . The resident's son and daughter-in-law were present and heard the noise. The Resident hit the left side of his/her head. The Resident was admitted to the hospital and . . . . . were applied.
- On . . . . . , the resident returned to the facility on continuous care with hospice.
- On . . . . . , the resident under Hospice care.
Hospital discharge instructions found in the resident's record showed that the resident was discharged from the hospital on . . . . . . The final diagnosis was: accidental ; blunt head .

In an interview on at 2:36 PM via telephone, Resident #7's daughter-in-law revealed that on both occasions on . . . , she put Resident #7 in bed and when she turned around, the resident got out of bed alone and . to the floor.

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A review of Resident #7's hospice record revealed that the admission date to the service was on [redacted] with a diagnosis of [redacted] and secondary diagnosis of [redacted] with behavioral disturbance.

Class III

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(8) FAC

Based on record review and interview, the Assisted Living Facility failed to ensure that two out of four sampled staff completed a minimum of 3 hours of continuing education related to Limited Mental Health (LMH) training (Manager and Staff C).

Findings included:

A review of Staff C's personnel file revealed that his/her hire date was on [redacted] and the last 3 hour LMH training was on [redacted].

A review of the Manager's personnel file revealed that his/her hire date was on [redacted] and the last 3 hours LMH training was on [redacted].

In an interview on [redacted] at 2:49 PM, the Administrator revealed that the LMH training just expired.

Class III