STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966381	**03/05/2018**
NAME OF PROVIDER OR SUPPLIER **MD HOME CARE, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **4857 NW 168 TERRACE** **OPA LOCKA, FL 33055**	

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

0000 - Initial Comments

A Complaint Survey (CCR#2018000338) was conducted on , 20 and concluded on , 2018. MD Home Care, Inc. (license #10585) had deficiencies identified at the time of the survey:

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

Based on record review and interview the facility failed to have a health assessment completed within 30 days of admission for one out of seven sampled residents (Resident #7).

Findings included:

Record review revealed Resident # 7 was admitted to the facility on and was discharged on . Record review revealed that the health assessment was computer generated. The first page was blank, the second and third page were completely filled out and the last page was not signed and dated by a healthcare provider.

On at 10:20 AM the administrator stated, "I do not know what happened."

Class III

0027 - Resident Care - Arrangement for Health Care - 58A-5.0182(3) FAC

Based on record review and interview the facility failed to make arrangements for 1 out of 7 sampled residents (Resident #1) who and hit the back of his head on the floor to be transferred to the hospital. Resident #1 was transferred to the hospital five days later after presenting with due to injuries from the . The hospital documented that Resident #1 had a skull and a hematoma.

Findings included:

Review of the hospital records received on for Resident #1 revealed the resident arrived to the hospital by emergency medical service ( ) due to a . Resident #1 was found in the back patio on the floor by the facility staff. The hospital records revealed Resident # 1 reportedly had a and struck his head while at the facility. "Since this incident, the patient has not been speaking and has minimally been following commands." The physical examination at the emergency department on showed an in the head located on the occipital scalp (back of the head). Results of the CT

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scan of the without contrast revealed that he had a nondisplaced and a nondepressed right occipital calvarial and had an acute .

Phone interview on at 5:10 PM a relative of Resident #1 stated, "Resident #1 is at a nursing home and now he has a feeding tube. He and they did not call rescue. He on Saturday ( ) and my relatives went to see him on Thursday ( ) and he was not talking and then the rescue was called. He does not recognize us. He walked but was unsteady that is why he . Now he cannot walk. He was on the head and they did not call the rescue."

Review of Resident #1's record revealed that the last health assessment was completed by the primary physician on and stated that the resident required assistance with all of his activities of daily living. It also stated that his gait was slow and unsteady with frequent loss of balance and elevated risk of . Review of the progress notes revealed the resident had a on where he hit the back of his head and was transferred to the hospital on .

On at 9:57 AM Staff A stated, "After the hurricane the owner put a shed on the patio and they were all curious about the shed. Resident #1 started to walk to the shed every day to look inside because he thought that we were hiding something in there. One day right in front of my eyes he went to turn and loss balance and . He hit the back of his head but it was only a scratch, it was not an open . He also scratched the . He did not want the rescue to be called."

On at 10:46 AM the Administrator stated in an interview, "That day Resident #1 had problems walking, he had lunch normally. His brother said that he was depressed. We were talking and I told his brother that we needed to call the rescue because he was not ok and he said to wait to the next day and I told him that I would not wait and called the rescue. He was not talking but was awake."

Class II

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation and interview the facility failed to offer privacy to one out of seven sampled residents (Resident #4), whose 's French glass door was not covered. The facility failed to ensure that a odor free for one out of seven sampled residents (#4).

Findings included:

During the tour of the facility on at 8:40 AM observed # had French glass doors which

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did not have curtains or covers. # also had a smell of .

Staff A stated on at 8:40 AM Staff A stated. "We are cleaning." At 8:45 AM she stated, "I removed the curtains recently because it looked better." The Administrator confirmed on at 11:00 AM that # had a odor.

Class III

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

Based on record review and interview the facility failed to keep accurate medication observation records for 5 out of 7 sampled residents (Residents #2, #4, #5, #6 and #7).

Findings include:

Review of the medication observation records (MORs) revealed that in some medication record pages for Residents #2, #4, # 5, #6 and #7 were missing the primary physician name and phone number and the section had been left blank. Record review revealed that there was no specific time for the medications to be given. It stated "AM" and "PM."

Review of Resident # 5's record revealed he was receiving hospice services and required medication administration. Review of the medication observation record revealed that the unlicensed staff from the facility were signing the medications as given on the MOR.

On at 9:24 AM Staff A stated Resident # 5 who is receiving hospice services the nurse comes in the morning and a friend came in the evening to give him the medications but the unlicensed staff in the facility has been signing them.

On at 10:58 AM the Administrator stated, "I have been doing the med sheets like that since 2004 and nobody said anything." She also stated, "Whoever give the medications will sign."

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview the facility failed to have medications locked up in the resident's the resident was absent.

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Findings included:

During tour of the facility on at 8:40 AM observed in # a tube of Ointment on top of the dresser. The was not locked and Resident #3 was not in the .

On at 8:40 AM Staff A stated, "Ok, thank you." and took the Ointment tube to the medication cabinet.

Class III

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

Based on record review and interview, the facility failed to have evidence of a negative examination documented on an annual basis for two out of four sampled staff (Staff B and D).

Findings included:

A review of Staff B's personnel file revealed that last examination was completed on (expired). Staff D's last ( ) examination was completed on (expired /2017).

During the exit interview on at 11:30 am Staff B stated, "she did not have because there was a mix up with the doctor telling her that her x-ray was good for 5 years." Staff B also stated that, she knows that Staff D needed to have a examination completed.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview the facility failed to keep an up-to-date admission discharge log.

Findings included:

Review of the admission/discharged log revealed Resident #7 was admitted to the facility on and had a discharge date of . The envelop where Resident #7's record was kept had a discharge date as .

On at 10:25 AM the Administrator stated, "It was a mistake, she was discharged on ."

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Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview the facility failed to have an updated demographic data sheet for 1 out of 7 sampled residents (Resident #1).

Findings included:

Record review revealed Resident # 1 had a . on . . . . The facility called one of the resident's sisters and they left a message for her to call back and she did not call back.

Review of the demographic sheet revealed that there were two of his sisters listed as emergency and the phone number of two of his sons were also listed, however the sister that they called was not listed.

On . . . . . at 9:57 AM Staff A stated, "One day right in front of my eyes Resident # 1 went to turn and lost balance and ; he hit the back of his head but it was only a scratch, it was not an open ; he also scratched the . . . . . He did not want the rescue to be called. I called his sister and left her a message to call me but she did not call me back"

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 file a one day and a fifteen day report with the agency for one out of seven sampled residents (Resident #1) that had a and was transferred to the hospital five days later due to . And it was discovered to have an occipital and a . . . . . hematoma.

Findings included:

Review of Resident # 1's record revealed that there was an internal incident report dated at 11:00 AM but the facility did not submit a one day and a fifteen days report to the agency.

On at 12:05 PM The administrator stated that since the resident refused to have the rescue called and was not transferred to the hospital on the day of the they did not file the report with the agency.

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Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on record review and interview the facility failed to provide evidence that the emergency plan was submitted for approval on an annual basis.

Findings included:

Review of the emergency plan approval letter posted in the bulletin board in the dining [redacted] that it was dated [redacted].

On [redacted] at 10:30 AM, The administrator stated, "I do not have the receipt because the consultant sent the emergency plan for me."

Class III

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

Based on observation, record review, and interview, the facility failed to provide documentation of a signed Attestation of Compliance with Background Screening for three out of four sampled staff (Staff A, B, and C). The facility also failed to maintain the eligibility results from employee background screenings' database for one out of four sampled personnel records (Staff D).

Findings included:

Review of the staff's personnel files revealed that Staff A, B, and C did not have a signed Attestation of Compliance with the background screenings. The facility failed to maintain the background screening's eligibility results for Staff D.

On . . . . at 11:32 AM, Staff B confirmed that Staff A and C; as well as herself were missing the attestation forms on file. She stated that she was unaware what the form was.

On . . . . . at 11:32 AM, an exit interview was conducted with Administrator who confirmed that Staff D has a new background screening, but that it's not in the file, and she was unable to find it at the time of the visit.

Class III