STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968275	05/07/2018
NAME OF PROVIDER OR SUPPLIER **OSMANI M ALF LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **26423 SW 122 PLACE** **HOMESTEAD, FL 33032**	

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

0000 - Initial Comments

An Abbreviated Biennial survey was conducted on , , 2018 and concluded on , 2018. Osmani M Alf Llc (license #12215) with limited mental health component had the following deficiencies identified at the time of the survey:

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on observation, interview, and record review, the Assisted Living Facility failed to ensure that two out of seven sampled residents met the admission criteria (Residents #1 and #2). The facility admitted Resident #2, who had a vacuum on the left chest and received through a midline by a pump. Resident #2 required 24 hour nursing services. The facility also admitted Resident #1, who needed total care for transfer, eating, and bath.

Findings included:

1. On at 9:45 AM a licensed practical nurse (LPN) from a home health agency arrived to facility. The LPN reported he was the nurse for Resident #2. The LPN said to Resident #2, "lets go to your you can have some privacy and I can check your ." The nurse revealed that the resident had an and a vacuum.

On at 10:10 AM Resident #2 revealed he had a , but the previous one became . The spread through his whole body. The resident needed ( ) due to the . The resident had a vacuum over the , site, on the left side of the chest, and received care on Monday, Wednesday, and Friday. Resident #2 revealed he was admitted to the facility on Friday , and that he needed assistance with transfer, bath, dressing, and medications.

On at 10:20 AM the LPN revealed Resident #2 started with the home health agency the day before and it was the first day Resident #2 starting receiving services.

Review of Resident #2's hospital record showed the admission date was on and the resident had a bloodstream . According to triage evaluation resident had to , and

Resident #2 had 3 , surgeries based on records received. His , was removed on due to , and reinserted on to Right upper chest. There was an order for

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care to left upper chest- cleanse normal solution 0.9%, dry, and inserted black foam into the , cover with dressing film and start vacuum at 125 mmHg. It was a surgical that measured 4 x 1.5 x 0.3. Resident #2 had a midline 16 Fr of single lumen to right inserted on . Resident received by an pump. Resident started on ( ) 2000 mg every 8 hours Curiln pump programmed intermittent mode. The nursing assessment note on at 10:25 stated "placed call to primary physician for removing resident from ALF but doctor did not answer."

Review of Resident #2's home health record revealed the resident was transferred from another home health agency on . Resident received services of physical ( ) injection, care ( ), care and administration. The comprehensive assessment completed on showed that last contact with physician was on . Resident #2 was admitted to the hospital diagnosis with , from to . The primary reason for the services was because Resident #2 had a left chest , MSSA (-sensitive ,) , , , emboli to lungs, , back/leg pain, functional decline. A rehabilitation (rehab) facility discharged Resident #2 to the ALF on . The doctor's order from the rehab dated order daily injections for , , , , vacuum to chest Monday, Wednesday, and Friday, and infuse Ancef 2g every 8 hours stop on .

On at 11:19 AM Resident #2's social worker revealed that staff from the facility met with Resident #2 at the rehabilitation facility. The staff reported they that could admit the Resident #2 to the ALF despite the resident needing 24 hour nursing services.

2. On at 9:17 AM there was a resident in # . # had one window with an open curtain that faced the street. The resident has only an incontinence brief. The resident had a right leg below the knee amputation as the resident rested in bed with full bed rails up.

On at 9:17 AM Staff B stated, "I always leave the resident like that after a shower so the resident can breathe." Staff B revealed she had to check the name on the medications because she did not know the resident's name. The resident had been there since the previous Monday. The resident's wife had surgery and resident was there while his recovered. Reconciliation of medications revealed the resident resting in bed in # was Resident #1.

Record review showed the facility did not have a record for Resident #1. The facility also did not have Medication Observation Records, a demographic sheet, medical history or doctor orders for Resident #1. The facility did not have an order for the use of bed rails or a consent for the use of bed rails.

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On at 10:59 AM, observed Resident #1 resting in bed with the lower legs hanging over the full bed rail.

On at 11:30 AM Staff B revealed Resident #1 was not able to talk, eat independently, ambulate independently, bath independently, and transfer independently. Staff had to feed and bathe the resident.

On at 12:29 PM Staff B fed Resident #1 mashed potatoes and roasted chicken in pieces.

3. Based on Agency staff recommendation the facility called an ambulance to removed both Residents #1 and Residents #2. The ambulance arrived to transfer Resident #1 out of the facility on at 1:44 PM. The administrator informed to ambulance staff that the facility did not have any medical history for Resident #1. On Resident #1 got out of bed at 1:51 PM when the ambulance took the resident to the hospital on the stretcher. An ambulance arrived on at 1:07 PM for Resident #2 and transferred the resident to the hospital.

Class II

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

Based on observation and record review, the Assisted Living Facility failed to treat residents with respect and with due recognition of personal dignity, individuality, and the need for privacy for one (#1) out of seven sampled residents. The facility also used full bed rails as a physical for one (#1) out of seven sampled residents.

Findings included:

Observed on at 9:17 AM a resident in # # had one window with an open curtain that faced the street. The resident rested in bed with full bed rails up. Resident was nude with only an brief on.

On at 9:17 AM Staff B stated, "I always leave the resident like that after a shower so the resident can breathe."

On at 9:17 AM Staff B revealed she had to check the name on the medications because she did not know the resident's name. The resident had been there since the previous Monday. The resident's wife had surgery and resident was there while his recovered. Reconciliation of medications

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revealed the resident resting in bed in # was Resident #1.

Class III

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

Based on observation, record review, and interview, the Assisted Living Facility failed to have Medication Observation Records (MORs) for one (Resident #1) out of seven sampled residents. The facility staff signed MORs for medications that licensed staff administered to one (#5) out of seven sampled residents. The facility failed to ensure the MORs included the name of the resident's health care provider, the health care provider's telephone number; strength, and directions for use of each medication and record each time is taken for one (#3) out of seven sampled residents.

Findings included:

1. On at 9:17 AM Resident #1 rested in bed with the full bed rail up in #.

Reconciliation of medications revealed the facility had the following medicines for Resident #1:
- 25 mg tablet- take half tablet by mouth daily.
- 5 mg tablet- take one tablet by mouth daily.
- 20 mg tablet- take one tablet by mouth every mouth.
- 25 mg tablet- take one tablet by mouth daily.
- 500 mg tablet- take one tablet by mouth before meal.
- 75 mg tablet- take one tablet by mouth daily.

On at 9:45 AM Staff B revealed that staff did not sign the MORs for Resident #1's medications. The facility did not have MORs for Resident #1. The resident was in the facility for few days.

2. Review of Resident #5's MORs revealed that there was an order for Lantus 100 units/ml - inject 10 units in the morning and 10 units in the afternoon. Unlicensed staff from the facility initialed at 7 AM the order from to and at 7 PM from to .

On at 9:30 AM Staff B revealed Resident #5 received from a home health agency and confirmed that the unlicensed staff should not have be initialed the MORs.

3. Review of Resident #3's MORs showed that there were an order for and an order

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, . . . 500 mg. The . . . , . . was scheduled in the morning; it did not show the strength of medication neither directions for use. The . . . , . . . was scheduled in the morning and afternoon; it did not show directions for use.

On at 10:22 AM Staff B confirmed that the MORs presented was for Resident #3. The staff revealed it was confusing but it was the MORs. Staff confirmed the MORs were not completed with the medication information.

Class III

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

Based on record review and interview, the Assisted Living Facility failed to have written statement from a health care provider documenting that two (Administrator and Staff C) out of four sampled staff did not have any signs or symptoms of communicable . . . . . within 30 days of employment.

Findings included:

Review of Administrator's personnel file revealed that hire date was on . . . . . There was no evidence of a written statement from a health care provider documentating that Administrator was free of communicable . . . . . .

Review of Staff C's personnel file revealed that hire date was on . . . . . There was no evidence of a written statement from a health care provider documentating that the staff was free of communicable . . . . . .

On . . . . . at 2:14 PM the Administrator revealed the facility did not have the communicable . . . . . for the Administrator and Staff C.

Class III

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

Based on record review and interview, the Assisted Living Facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period.

Findings included:

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Review of the staff schedule showed for the week of - , the Administrator was scheduled to work from 12 PM to 8 PM from Sunday to Friday. Staff B was scheduled to work from 7:00 AM to 4:00 PM from Sunday to Saturday except Tuesday. Staff C was scheduled to work from 7 AM to 3 PM from Monday to Saturday. Staff D was scheduled to work from 8 PM to 7 AM from Sunday to Saturday except Wednesday that was off.

On at 2:23 PM Staff B revealed that Staff C and D went to Tampa, they were not working. Staff B was working for them.

Review of Staff D's personnel record revealed the First Aid and training expired on 2017. The facility failed to provide documentation of current First Aid and training.

On at 11:10 AM Staff D revealed he usually worked the night shift alone.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the Assisted Living Facility failed to have required furniture in resident's .

Findings included:

Observed on at 9:17 AM # did not have closet, table or nightstand, and waste basket. There was an extra mattress against the wall. Resident #2's bed and two wheelchairs.

On at 9:21 AM observed that there were 2 beds and two dressers in # . One of the beds was items place on it. The other bed had boxes and furniture on it. # did not have table or nightstand, bedside lamp or floor lamp and waste basket.

On at 9:27 AM observed # did not have table or nightstand, bedside lamp or floor lamp and waste basket.

On at 9:21 AM Staff B stated, "I was preparing and cleaning for survey. It is too early. Survey is supposed to be on ."

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

Based on observation, record review and interview, the Assisted Living Facility failed to keep an updated admission and discharge log. The facility did not include Resident #1 in the admission and discharge log. Resident #6 had a different admission date in demographic sheet that in admission and discharge log.

Findings included:

On at 9:12 AM Residents #2 and #6 were in the living .

On at 9:15 AM Staff B revealed there were six residents. There were seven people in the facility but it was not what it looked like.

On at 9:16 AM Residents #3 and #4 were two residents in #.

On at 9:17 AM Resident #1 rested in bed with full bed rails up in #.

On at 9:17 AM Staff B revealed Resident#1's wife had surgery and the resident was there while Resident's wife recovered. The resident has been there since previous Monday.

On at 9:27 AM Residents #5 and #7 rested in #.

On at 11:10 AM Staff D revealed that there were seven residents during the night shift of .

Review of admission and discharge log showed that Resident #1 was not included. Resident #6 admission date was .

Review of Resident #6's record showed that demographic sheet had admission date on . The resident had an agreement with the facility on .

On at 12:36 PM the Administrator stated, "I don't know. Maybe Resident #6 left and came back, and I started a new record."

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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 a signed attestation in the employee's personnel file for one out of four sampled staff (Staff C).

Findings included:

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

On at 2:16 PM the administrator revealed that did not realize that the attestation of compliance with background screening requirements was missing the signature from that staff.

Class III

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

Based on record review and interview, the Assisted Living Facility (ALF) failed to ensure have updated resident records included resident demographic data for two (Residents #6 and #7) out of seven sampled residents. The facility was not sure about the admission date for one (Resident #6) out of seven sampled residents. The facility did not update the telephone numbers of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency for Resident #6. The facility did not complete a new demographic sheet verifying all the information and updating the admission date for Resident #7.

Findings included:

1. Review of Resident #6's record showed that demographic sheet had admission date on . The resident had an agreement with the facility on . Review of admission and discharge log showed the Resident #6's admission date was .

On at 12:36 PM the Administrator stated, "I don't know. Maybe Resident #6 left and came back, and I started a new record."

2. Review of Resident #6's demographic sheet showed just one person as next of kin, legal representative, or individual designated by the resident for notification in case of an emergency.

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On at 5:06 PM a woman returned the call from one of the phone numbers listed in Resident #6's demographic sheet for notification in case of an emergency. The person revealed that did not have any any family member or any known person in an ALF.

Review of Resident #7's demographic sheet showed that it was from previous facility. It showed admission date on . Review of facility admission and discharge log showed that Resident #7 admission date was on .

On at 2:00 PM the Administrator revealed they needed to complete a new demographic sheet because it was the same information.

Class III

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

Based on record review and interview, the Assisted Living Facility failed to resubmit the emergency plan to the local emergency management agency within 30 days of receiving notification,

Findings included:

Review of Comprehensive Emergency Management Plan Approval Letter revealed that last approved was on . The facility received a letter on informing the facility that they needed to send the updated Comprehensive Emergency Management Plan by . Facility had proof of payment dated on .

On at 10:33 AM the Administrator revealed that submitted the Emergency Plan on .

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 staff received a minimum of 6 hours of Limited Mental Health training within 6 months of employment in a a limited mental health facility for two(Administrator and Staff C) out of four sampled staff. The facility failed to ensure that staff received a minimum of 3 hours of continuing education of Limited Mental Health (LMH) training every two years in a a LMH facility for one (Staff D) out of four sampled staff.

Findings included:

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Review of Administrator's personnel file revealed the hire date was on . . . . . There was no evidence of completion of a minimum of 6 hours of of Limited Mental Health training.

Review of Staff C's personnel file revealed the hire date was on . There was no evidence of completion of a minimum of 6 hours of of Limited Mental Health (LMH) training.

Review of Staff D's personnel file revealed the hire date was on . . . . . The 3 hours of continuing education of Limited Mental Health training in record was on .

On at 2:14 PM the Administrator revealed that was not able to find the LMH training.

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Z828 - Administrative Fines; Violations - 408.813(3) FS

Based on observation, record review, and interviews, the Assisted Living Facility (ALF) exceeded licensed capacity of 6, the facility had a census of 8 residents.

Findings included:

On at 9:12 AM observed two residents in the living , Residents #2 and #6.

On at 9:15 AM Staff B revealed that there were six residents. There were seven people in the facility but it was not what it looked like.

On at 9:16 AM there were two residents in # . On at 9:16 AM Staff B revealed that residents in # were Residents #3 and #4.

On at 9:17 AM there was a resident in # . The resident rested in bed with full bed rail up. The resident had a right leg below the knee amputation. The resident had an brief on and was nude.

On at 9:17 AM Staff B revealed she had to check the name on the medications because she did not know the resident's name. The resident had been there since the previous Monday. The resident's wife had surgery and resident was there while his recovered. Reconciliation of medications revealed the resident resting in bed in # was Resident #1.

On at 9:27 AM observed Residents #7 and #5 resting in # .

On at 9:43 AM Staff B stated, "Yes, we have medicines for the seven residents."

On at 11:10 AM Staff D revealed that there were seven residents during the night shift of .

Reconciliation of medications in the ALF revealed medications for Residents #1, #2, #3, #4, #5, #6, and #7. The facility also had medication observation records for Residents #2, #3, #4, #5, #6 and #7.

Unclassified