STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967363	06/14/2018
NAME OF PROVIDER OR SUPPLIER **WHISPERING PINES HOME CARE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8830 SW 196TH DRIVE CUTLER BAY, FL 33157**	

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

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

Based on observation, record review, and interview, the facility failed to operate within their licensed capacity. The facility is licensed for 6 residents; however, 13 residents were found to be at the facility during survey.

Findings included:

On . . . . . at 8:20 AM arrived to the facility was met with a person who identified himself as the owner's boyfriend. Observed two staff members present in the facility (Staff C and Staff D).

On at 8:22 AM further observations found Resident #7 and Resident #8 in recliner chairs. The residents were observed unable to ambulate without assistance.

Conducted the initial facility tour with Staff D on . . . . . at 8:25 AM. Observations in the common . Resident #4, Resident #3 (observed to be), and Resident #9 (observed to ambulate without assistance) sitting chairs. Observed Resident #10 sitting in dining . . . . breakfast cereal with milk. Staff D stated # belonged to Resident #2 and in # Resident #9, # Resident #3 & Resident #4. Observed Resident #11 coming out of the . . . . , she stated he lives there and she has been living in the facility for two years. In the Florida Resident #13 and Resident #5 sitting in recliner chairs. Observed a . . Staff D stated was the Administrator's . The the left staff stated belonged to the Administrator's boyfriend. Observed a staff stated was the facility's office, down the hall was a . . . . belonged to Resident #1.

On . . . . . at 8:59 AM Resident #1 stated he was there for a few days while his brother out on vacation. Observed the resident had a (, ,) line on his right arm and his left foot had a dressing. The . . line is a . . . . that enters the body through the skin (,) at a , site, extends to the , . . . (a central . . trunk). Resident #1 stated "I administer my medication through the . . line, I do it myself. I recently got out of the hospital because I am a . I have an , I need to drain it. I have been calling the hospital to arrange for a nurse, but because of the long weekend I have not been able to get through them."

On . . . . . at 9:00 AM outside in patio was Resident #6 and Resident #12 sitting in patio chairs, they both stated they live in the facility. Also, observed Resident #2 was outside in the patio.

On at 9:10 AM the Administrator arrived to the facility. She reported there are five residents (Resident #2, Resident #5, Resident #4, Resident #3, and Resident #6) in the facility and Resident #7

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was in the process of being admitted as a resident. Resident #7 had already been living in the facility. The administrator revealed the remaining resident were day care participants (Resident #9, Resident #8, Resident #11, Resident #10, Resident #13, and Resident #12.)

On at 9:40 AM a second tour was conducted with the Administrator, she reported # belonged to Resident #6 and Resident #5. In # Resident 3 hospice resident and Resident #4. In # Resident #7. In # Resident #2 (observed bed was a trundle with a mattress). The administrator stated the trundle was brought by the resident's family. Observed a private , the Administrator stated the to her daughter who is . The a queen size bed and one size bed. Observed a black bag that contained packets of medication that belonged to Resident #3, Resident #10, Resident #12, Resident #4, Resident #7, Resident #14 (expired resident), Resident #2, Resident #11, and Resident #8. Found a the left, the Administrator reported belonged to her, there was another belonged to the Administrator's boyfriend.

Further observations on 9:56 AM observed a an office, the Administrator was upset and hesitant to open the door . She stated this was her private office and this area was not in the plans of the facility. Observed in the office there was resident files, facility files, and medication that belonged to residents in the facility.

On 10:01 AM observed two sheds in the backyard and one small in the back. The Administrator stated they needed to get the key for those sheds. Observed one shed in the back was converted to a another shed. There was a small , with a bed, a television, and small air condition unit. The bed was observed to be dirty and there was clutter throughout the whole .

On at 11:50 AM Resident #10 stated, "I have been living here for almost 2 years. My the first , I sleep in the Resident #9. The staff gives me my medication, they do my laundry and they prepare the food. I do not have any family, they never visit me. I had adoptive parents. Mostly we watch television all day."

On at 11:55 PM Resident #11 stated "I have been living here for almost 2 years. My son and daughter visit me. My the the hall, I have a , I don't know her name. They do my laundry and I get my meals."

On at 12:18 PM Resident #9 stated, "I have been living here for about 15 or 16 months. They give me my medication, the staff gives it to me. I get my meals, and they do my laundry."

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SUMMARY STATEMENT OF DEFICIENCIES
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A review of the health finder darabase revealed the facility is licensed for 6 beds.

Unclassified

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SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

A Standard Biennial Survey was conducted on , , 2018 and concluded on , 2018. Whispering Pines Home Care Inc. (License #11423) had the following deficiencies identified at time of the survey:

0004 - Licensure - Requirements - 58A-5.016 FAC

Based on record review and interview, the facility failed to provide an annual satisfactory health inspection.

Findings included:

A review of the facility's health inspection report revealed the inspections expired on .

On at 9:10 AM Administrator stated "The health department expires on , /2018. This permit says expired ."

Class III

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

Based on observation, interview, and record review, the facility failed to ensure that 1 out of 13 sampled residents met the admission criteria (Residents #1). The facility admitted Resident #1, who had a , , , (line) on his right arm and a left foot with a vacuum. Resident #1 required 24 hour nursing services.

Findings included:

On at 8:59 AM observed Resident #1 in the last the hall in the back of the facility. The resident had a (, , ,) line on his right arm and dressing to his left foot. The line is a that enters the body through the skin (, ,) at a , , site, extends to the , (a central trunk).

On at 8:59 AM Resident #1 stated he was there for a few days while his brother out on vacation. Resident #1 stated, "I administer my medication through the line, I do it myself. I recently got out of the hospital because I am a . I have an , I need to drain it. I have been

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calling the hospital to arrange for a nurse, but because of the long weekend I have not been able to get through them."

Record review found the facility did not have any records for Resident #1. The facility did not have discharge orders for the line or care. The records the facility did not have or coordinate with a licensed nurse to perform skilled nursing. A review of staff files revealed none of the staff were a licensed registered nurse. Resident #1 was transferred to the hospital after Agency staff intervention.

Hospital records from revealed Resident #1's medical history of chronic of skin, , and osteomyeliutis. Additional medical history of foot to heel and line. check documented patient with double lumen to right upper extremity and with vac to left lower extremity s/p (status/post) partial amputation. An online medical dictionary describes a vac as a treatment for surgical wounds consisting of a pump that applies negative pressure to a space via tubing inserted into the .

On at 3:00 PM the Administrator stated she had contacted the hospital, and spoke to a social worker regarding Resident #1. She stated a nurse was supposed to be arranged for the resident but the social worker had not contacted her, and that the only documents she had received were his discharge papers."

Class II

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

Based on observation, record review, and interview, the facility failed to honor resident rights for dignity and respect by providing a safe and decent living environment for 2 out of 13 sampled residents. Resident #2 was living in a shed in backyard of the facility after the facility being licensed for 6 beds had a census of 13 residents.

Findings included:

1) A review of the health finder database revealed the facility is licensed for 6 beds.

On at 9:10 AM during the facility tour observed the facility had 13 residents despite being licensed for 6 beds. Further observations found the facility had a odor in some of the areas. In # a bed with a trundle with a mattress under the bed. The Administrator stated the trundle was brought by the Resident #2's family. Observed Resident #2 outside on the patio.

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A review of Resident #2's file showed the resident was admitted on . . . . . Resident #2's health assessment dated had a medical history and diagnoses of . . . . . , high . . . . . , prostatic hyperplasia, and . The resident required supervision ambulation, bathing, dressing, self-care (. . . .), and transferring. The resident needs assistance with self-administration of medications.

On at 9:40 AM during the second facility tour, observed one shed in the backyard of the facility which was converted to a . . . . . found another . . . . . shed. There was a small shed, with a bed, a television, and small air condition unit. The bed observed soiled and there was clutter throughout the shed.

On . . . . . at 9:45 AM observed the Administrator's boyfriend open the sheds outside in the backyard of the facility. Observed 3 sheds with tools and other storage parts inside. There was one shed with a toilet and a sink. There was a shed with windows in the back of the backyard, the door was unlocked and there was a a bed, TV, refrigerator, A/C, fan. According to the Administrator boyfriend, no one used the . . . . There was a refrigerator with a chain and locked located on the back porch of the house, inside were medications for Resident #14. All medications dated from 2017 and new medications dated . . . . . , the same day that the Resident passed.

On . . . . . at 3:38 PM Resident #6 stated, "Resident #2 lives by himself in the . . . . . in the patio."

2) Facility tour with Staff D on at 8:25 AM found Resident #3 in the common area.

On at 11:16 AM interview with Resident #3's son revealed "I feel the home can be better, the cleaning can be improved there is some . . . smell sometimes. I feel they could take better care of her."

Class II

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

Based on observation and interview, the facility failed to follow the correct procedure as outlined in section 429.456 of Florida Statutes, when assisting 1 out of 13 sampled residents with self-administration of medications (Resident #5).

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Findings included:

On at 12:00 PM observed Staff C assist Resident #5 with self-administered medication. The staff washed her hands was not wearing gloves from the packet. Staff C grabbed the medication with her hands, handed the medication to the resident, and handed her a cup with water. The facility staff did not take the medication from the original container to the resident's hand.

On at 12:30 PM Staff C stated she grabbed the medication because she had washed her hands.

Class III

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

Based on observation, record review, and interview, the facility failed to dispose medications within 30 days of being determined abandoned or expired and document the disposal in the residents' record for 3 out of 13 sampled residents (Residents #3, #12 and #14).

Findings included:

Record review for Resident #3 showed admission date . Record review for Resident #12 showed under Adult Care. Record review for Resident #14 showed admission date , date .

On at 10:15 AM during the facility tour, observed expired medications inside a locked closet located in the facility's hallway: Prescribed Thick It with expiration date of and prescribed Shampoo with expiration date of . Medication Acetic .25 % with expiration date These medications belonged to Residents who no longer resided at the facility. Also, observed a refrigerator/freezer with a locked chain located at the back porch of the facility with expired and new medications who belonged to a Resident, Resident #14: Lorazepan issued , issued , issued , issued , issued , issued , Comfort Pack, issued , Comfort Pack, issued , Lorazepan, issued , issued , issued , issued and , issued . Medications for Resident #3: Lorazepan, issued , issued , issued , issued and , issued

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. Medications for Resident #12: Sol 10 mg (2 bottles) with expiration dates .

On , 2018 at 10:30 am, the Administrator did not have any comments on the medications found.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review and interview the facility failed to ensure that one out of four sampled employees had received training in the areas of Incident Reporting, Resident Rights, and Recognizing & Reporting , Neglect, & , with 30 days of employment (Staff B).

Findings included:

A review of Staff B's employee revealed there was no documentation the staff received the Incident Reporting, Resident Rights, and Recognizing & Reporting , Neglect, & , training. Staff B was hired on .

On at 2:42 PM the Administrator stated, "Any of the training in the files missing I have, I just have them in my office because I was working on the files."

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on observations and interview, the facility failed to provide documentation that one out of four sampled staff received the required annual continuing education training in assisting residents with self-administration of medications (Staff D).

Findings included:

A review of Staff D's employee file showed the last training in assisting residents with self-administration of medication was received on .

On at 3:00 PM observed Staff D assisting Resident #10 with self-administration of medications.

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Class III

0085 - Training - Nutrition & Food Service - 58A-5.0191(6) FAC

Based on observation, record review, and interview the facility failed to provide documentation that one out four sampled staff that provide food services had completed the food service designee training (Staff C).

Findings Included:

On . . . . . at 12:00 PM observed Staff C preparing lunch and serving the meal to the residents.

A review of Staff C's employee file showed the staff was hired on . . . . . and there was no documentation the food service training. The last safe food training was dated . . . . .

On at 2:42 PM the Administrator stated, "Any of the training in the files missing I have, I just have them in my office because I was working on the files."

Class III

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

Based on record review and interview, the facility failed to provide documentation of an updated Emergency Management Plan submitted and approved by the local agency.

Findings included:

A review of the facility's bulletin board showed that the last approved emergency management plan was dated . . . . . .

On at 9:10 AM the Administrator stated, "I already submitted the plan but I have not received the approval."

Class III

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

Based on record review and interview, the facility failed to ensure two out of four sampled staff

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completed the limited mental health minimum of 3 hours of continuing education (Staff A and C).

Findings included:

A review of the facility's license found it have the limited mental health component on the license.

A review of Staff A's employee file showed the last mental health continuing education was completed on . . . . .

A review of Staff C's employee file showed the last mental health continuing education was completed on .

On at 2:42 PM the Administrator stated, "Any of the training in the files missing I have, I just have them in my office because I was working on the files."

Class III

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

Based on observation, record review, and interview, the facility failed to operate within their licensed capacity. The facility is licensed for 6 residents; however, 13 residents were found to be at the facility during survey.

Findings included:

On . . . . . at 8:20 AM arrived to the facility was met with a person who identified himself as the owner's boyfriend. Observed two staff members present in the facility (Staff C and Staff D).

On at 8:22 AM further observations found Resident #7 and Resident #8 in recliner chairs. The residents were observed unable to ambulate without assistance.

Conducted the initial facility tour with Staff D on . . . . . at 8:25 AM. Observations in the common . Resident #4, Resident #3 (observed to be), and Resident #9 (observed to ambulate without assistance) sitting chairs. Observed Resident #10 sitting in dining . . . . breakfast cereal with milk. Staff D stated # belonged to Resident #2 and in # Resident #9, # Resident #3 & Resident #4. Observed Resident #11 coming out of the . . . . , she stated he lives there and she has been living in the facility for two years. In the Florida Resident #13 and Resident #5 sitting in recliner chairs. Observed a . . Staff D stated was the Administrator's . The the left staff stated belonged to the Administrator's boyfriend. Observed a staff stated was the facility's office, down the hall was a . . . . belonged to Resident #1.

On . . . . . at 8:59 AM Resident #1 stated he was there for a few days while his brother out on vacation. Observed the resident had a (, ,) line on his right arm and his left foot had a dressing. The . . line is a . . . . that enters the body through the skin (,) at a , site, extends to the , . . . (a central . . trunk). Resident #1 stated "I administer my medication through the . . line, I do it myself. I recently got out of the hospital because I am a . I have an , I need to drain it. I have been calling the hospital to arrange for a nurse, but because of the long weekend I have not been able to get through them."

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Class III

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On at 3:00 PM the Administrator stated she had contacted the hospital, and spoke to a social worker regarding Resident #1. She stated a nurse was supposed to be arranged for the resident but the social worker had not contacted her, and that the only documents she had received were his discharge papers."

Class II

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

Based on observation, record review, and interview, the facility failed to honor resident rights for dignity and respect by providing a safe and decent living environment for 2 out of 13 sampled residents. Resident #2 was living in a shed in backyard of the facility after the facility being licensed for 6 beds had a census of 13 residents.

Findings included:

1) A review of the health finder database revealed the facility is licensed for 6 beds.

On at 9:10 AM during the facility tour observed the facility had 13 residents despite being licensed for 6 beds. Further observations found the facility had a odor in some of the areas. In # a bed with a trundle with a mattress under the bed. The Administrator stated the trundle was brought by the Resident #2's family. Observed Resident #2 outside on the patio.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967363	06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES HOME CARE INC	**8830 SW 196TH DRIVE CUTLER BAY, FL 33157**

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

A review of Resident #2's file showed the resident was admitted on . . . . . Resident #2's health assessment dated had a medical history and diagnoses of . . . . . , high . . . . . , prostatic hyperplasia, and . The resident required supervision ambulation, bathing, dressing, self-care (. . . .), and transferring. The resident needs assistance with self-administration of medications.

On at 9:40 AM during the second facility tour, observed one shed in the backyard of the facility which was converted to a . . . . . found another . . . . . shed. There was a small shed, with a bed, a television, and small air condition unit. The bed observed soiled and there was clutter throughout the shed.

On . . . . . at 9:45 AM observed the Administrator's boyfriend open the sheds outside in the backyard of the facility. Observed 3 sheds with tools and other storage parts inside. There was one shed with a toilet and a sink. There was a shed with windows in the back of the backyard, the door was unlocked and there was a a bed, TV, refrigerator, A/C, fan. According to the Administrator boyfriend, no one used the . . . . There was a refrigerator with a chain and locked located on the back porch of the house, inside were medications for Resident #14. All medications dated from 2017 and new medications dated . . . . . , the same day that the Resident passed.

On . . . . . at 3:38 PM Resident #6 stated, "Resident #2 lives by himself in the . . . . . in the patio."

2) Facility tour with Staff D on at 8:25 AM found Resident #3 in the common area.

On at 11:16 AM interview with Resident #3's son revealed "I feel the home can be better, the cleaning can be improved there is some . . . smell sometimes. I feel they could take better care of her."

Class II

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

Based on observation and interview, the facility failed to follow the correct procedure as outlined in section 429.456 of Florida Statutes, when assisting 1 out of 13 sampled residents with self-administration of medications (Resident #5).

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

Findings included:

On at 12:00 PM observed Staff C assist Resident #5 with self-administered medication. The staff washed her hands was not wearing gloves from the packet. Staff C grabbed the medication with her hands, handed the medication to the resident, and handed her a cup with water. The facility staff did not take the medication from the original container to the resident's hand.

On at 12:30 PM Staff C stated she grabbed the medication because she had washed her hands.

Class III

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

Based on observation, record review, and interview, the facility failed to dispose medications within 30 days of being determined abandoned or expired and document the disposal in the residents' record for 3 out of 13 sampled residents (Residents #3, #12 and #14).

Findings included:

Record review for Resident #3 showed admission date . Record review for Resident #12 showed under Adult Care. Record review for Resident #14 showed admission date , date .

On at 10:15 AM during the facility tour, observed expired medications inside a locked closet located in the facility's hallway: Prescribed Thick It with expiration date of and prescribed Shampoo with expiration date of . Medication Acetic .25 % with expiration date These medications belonged to Residents who no longer resided at the facility. Also, observed a refrigerator/freezer with a locked chain located at the back porch of the facility with expired and new medications who belonged to a Resident, Resident #14: Lorazepan issued , issued , issued , issued , issued , issued , Comfort Pack, issued , Comfort Pack, issued , Lorazepan, issued , issued , issued , issued and , issued . Medications for Resident #3: Lorazepan, issued , issued , issued , issued and , issued

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WHISPERING PINES HOME CARE INC	**8830 SW 196TH DRIVE CUTLER BAY, FL 33157**

SUMMARY STATEMENT OF DEFICIENCIES
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. Medications for Resident #12: Sol 10 mg (2 bottles) with expiration dates .

On , 2018 at 10:30 am, the Administrator did not have any comments on the medications found.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review and interview the facility failed to ensure that one out of four sampled employees had received training in the areas of Incident Reporting, Resident Rights, and Recognizing & Reporting , Neglect, & , with 30 days of employment (Staff B).

Findings included:

A review of Staff B's employee revealed there was no documentation the staff received the Incident Reporting, Resident Rights, and Recognizing & Reporting , Neglect, & , training. Staff B was hired on .

On at 2:42 PM the Administrator stated, "Any of the training in the files missing I have, I just have them in my office because I was working on the files."

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on observations and interview, the facility failed to provide documentation that one out of four sampled staff received the required annual continuing education training in assisting residents with self-administration of medications (Staff D).

Findings included:

A review of Staff D's employee file showed the last training in assisting residents with self-administration of medication was received on .

On at 3:00 PM observed Staff D assisting Resident #10 with self-administration of medications.

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

Class III

0085 - Training - Nutrition & Food Service - 58A-5.0191(6) FAC

Based on observation, record review, and interview the facility failed to provide documentation that one out four sampled staff that provide food services had completed the food service designee training (Staff C).

Findings Included:

On . . . . . at 12:00 PM observed Staff C preparing lunch and serving the meal to the residents.

A review of Staff C's employee file showed the staff was hired on . . . . . and there was no documentation the food service training. The last safe food training was dated . . . . .

On at 2:42 PM the Administrator stated, "Any of the training in the files missing I have, I just have them in my office because I was working on the files."

Class III

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

Based on record review and interview, the facility failed to provide documentation of an updated Emergency Management Plan submitted and approved by the local agency.

Findings included:

A review of the facility's bulletin board showed that the last approved emergency management plan was dated . . . . . .

On at 9:10 AM the Administrator stated, "I already submitted the plan but I have not received the approval."

Class III

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

Based on record review and interview, the facility failed to ensure two out of four sampled staff

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SUMMARY STATEMENT OF DEFICIENCIES
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completed the limited mental health minimum of 3 hours of continuing education (Staff A and C).

Findings included:

A review of the facility's license found it have the limited mental health component on the license.

A review of Staff A's employee file showed the last mental health continuing education was completed on . . . . .

A review of Staff C's employee file showed the last mental health continuing education was completed on .

On at 2:42 PM the Administrator stated, "Any of the training in the files missing I have, I just have them in my office because I was working on the files."

Class III