STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965650	06/25/2018
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

An unannounced licensure complaint survey (CCR#2018004935) was conducted on [redacted] at Res-Care Premier. (License #10009). The facility had deficiencies identified at the time of the visit.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on interview and records review, the facility failed to ensure adequate supervision was provided to two of six residents (Resident #1 & #2) in order to prevent possible injury to Resident #1 and physical harm to Resident #2.

The findings included:

Review of Resident #1's record revealed an admission date of [redacted], which was a mandate by the Courts, after the resident's care manager had made the recommendation. The court documents further stipulated that Resident #1 could only receive visitation from immediate family members to include mother, father, the Resident's sister and other immediate family members. This order is to remain in effect until such time has the court ruled against it.

Review of Resident #1's health assessment (AHCA form 1823) revealed that the resident had the following diagnoses: [redacted], type I; [redacted]; right [redacted]; [redacted] following [redacted]; [redacted], change secondary to history [redacted]. Further review of the AHCA form 1823 indicated that Resident #1 presents, a flat affect during communication most of the time, aggressive behaviors with authority and is at times physically aggressive. He also has recurrent episodes of fleeing in the past (elopement risk).

Review of the facility's incident reports revealed the resident has eloped from the facility multiple times. On [redacted] the resident eloped, the Police was contacted and they were able to locate the resident and returned him to the facility. On [redacted] during a routine check in the Resident's [redacted], the facility's staff noted that Resident #1 was missing. They called the police and at 2:30 A. M., they found the resident in the streets intoxicated and the police took him to a nearby hospital. A staff member picked the resident from the hospital the following day and brought him back to the facility.On [redacted], a documentation revealed that Resident #1 had a verbal argument with Resident #2 at the facility's porch. Resident #2 left Resident #1 outside and went inside to the kitchen. Resident #1 then followed Resident #2 to the kitchen and kicked him causing Resident #2 to [redacted] on the floor and sustaining injuries (scrapes) to his arm and above his right eye. On [redacted], Resident #1 was verbally aggressive towards another resident, as per reviewed documents. When the Administrator intervened, Resident #1 directed his verbal aggression

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towards the Administrator and even attempted to the Administrator. His anger was uncontrollable and he broke the television in his . The facility called the Police who had difficulty appeasing Resident #1's anger. He was eventually .

During an interview with the Administrator on , at 12:38 PM, he reported that the facility has sought behavioral assistance for the Resident. However, the Administrator agreed that the has not been effective in keeping the resident's continued verbal and physical aggression under control.

During an interview with Resident #2 on at 10:30 AM, he reported that his relationship with Resident #1 is "not the best". They are nevertheless obliged to share the same neither is able to afford a private . Additionally, observation and interview with the Administrator confirmed that the facility does not have any more private or semi-private available. Resident #2 further indicated that he is not afraid of Resident #1, despite Resident #1's aggressive temperament. He reported that he has been a resident at the facility for a long time.
An observation of his right arm revealed some . When questioned about their origin, he said that they might have been from Resident #2, but he was not sure. Review of the health Assessment form 1823 revealed that Resident #2 had diagnoses of , and that he had a history of ; he also had , Chronic and mobile limitations (unsteady gait).

Review of the Medication Observation Record revealed that Resident #1 had orders for tablet 10 mg for to take daily, but he refused to take it. The physician discontinued the medication on . Furthermore, Resident #1's 1823 revealed that he is appropriate to resident at the facility. His medications list included: 500 mg (take 1 tablet twice a day by mouth (PO); 2000 mg twice daily PO; 10 mg , PO; 81 mg daily; 600 mg 2 times daily; Sliding Scale; Flex; Disposable Needles. The MOR indicated that Resident #1 refused three out of five of his ordered medications as verified in the Medications Observation record. The facility informed the Resident's Psychiatrist on that the resident refused to take his ordered 40 mg and the Neurologist on , 2018 about the resident's refusal to take his prescribed medications of and . The physician discontinued all the medications that the resident had refused; currently, Resident #1 takes ; and for .

Review of the facility's staffing pattern showed that there is only one staff member per shift every day.
During an interview with the Administrator, on at 12:38 PM, he reported that he is in the process of interviewing possible for employment. Observation conducted upon entering the facility on

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at 9:00 AM revealed that there was no door alarm. An inquiry at 12:49 PM regarding a possible alert system observed at the door triggered the Administrator to report that they do have a door alarm. After opening the door however, the Administrator realized that the door alarm system was not active, it was unplugged. He plugged it and the alarm operated normally.

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on record review and interview, it was determined that the facility failed to ensure 1 of 6 residents (Resident #1) at risk for elopement had identification on this person at all times, including the facility staff daily ensuring the identification is on the person.

The findings included:

Review of Resident #1's record revealed an admission date of , which was a mandate by the Courts, after the resident's care manager had made the recommendation. The court documents further stipulated that Resident #1 could only receive visitation from immediate family members to include mother, father, the Resident's sister and other immediate family members. This order is to remain in effect until such time has the court ruled against it.

Review of Resident #1's health assessment (AHCA form 1823) revealed that he had the following diagnoses: , type I; ; right , ; following ; , change secondary to history . Further review of the 1823 indicated that Resident #1 presented, a flat affect during communication most of the time, aggressive behaviors with authority and is at times physically aggressive. He also has recurrent episodes of fleeing in the past (elopement risk).

Review of the facility's incident reports revealed the resident has eloped from the facility multiple times and on at least two occasions. On the resident eloped, the Police was contacted and they were able to locate him and returned him to the facility. On during a routine check in the Resident's , the facility's staff noted that Resident #1 was missing. They called the police and at 2:30, A. M. they found the resident in the streets intoxicated and the police took him to a nearby hospital. A staff member picked the resident from the hospital the following day and brought him back to the facility.

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On , Resident #1 was verbally aggressive towards another resident, as per reviewed documents. When the Administrator intervened, Resident #1 directed his verbal aggression towards the Administrator and even attempted to the Administrator. His anger was uncontrollable and he broke the television in his . The facility called the Police who had difficulty appeasing Resident #1's anger. He was eventually .

During an interview with the Administrator on , at 12:38 PM, this writer asked whether Resident #1 had an identification on his person, he stated "no". However, the Administrator indicated that Resident #1 would not keep the identification on his person even if this action was implemented. Resident was not present during the visit, he attended a day program in the community.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on interview and records review, the facility failed to file multiple initial adverse incident reports within one day of he incident and a full adverse incident report within fifteen days of elopement incidents and incidents in which the local police deparment were involved to the agency for one of six Residents (Resident #1).

The findings included:

Review of Resident #1's record revealed an admission date of , which was a mandate by the Courts, after the resident's care manager had made the recommendation. The court documents further stipulated that Resident #1 could only receive visitation from immediate family members to include mother, father, the Resident's sister and other immediate family members. This order is to remain in effect until such time has the court ruled against it.
Review of Resident #1's health assessment (AHCA form 1823) revealed that he had the following diagnoses: , type I; ; right , , ; following ; , change secondary to history . Further review of the 1823 indicated that Resident #1 presented, a flat affect during communication most of the time, aggressive behaviors with authority and is at times physically aggressive. He also has recurrent episodes of fleeing in the past (elopement risk).

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On , Resident #1 was verbally aggressive towards another resident, as per reviewed documents. When the Administrator intervened, Resident #1 directed his verbal aggression towards the Administrator and even attempted to the Administrator. His anger was uncontrollable and he broke the television in his . The facility called the Police who had difficulty appeasing Resident #1's anger. He was eventually .

Observation conducted upon entering the facility on at 9:00 AM revealed that there was no door alarm. An inquiry at 12:49 PM regarding a possible alert system observed at the door triggered the Administrator to report that they do have a door alarm. After opening the door however, the Administrator realized that the door alarm system was not active it was unplugged. He plugged it and the alarm operated normally, following surveyor intervention.

Class III