STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966601	**08/15/2018**
NAME OF PROVIDER OR SUPPLIER **BJ HOME CARE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2218 SW 26 LANE** **MIAMI, FL 33133**	

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

0000 - Initial Comments

A Complaint Survey (CCR#2018011744) was conducted on and concluded on . BJ Home Care Inc. with a Limited Mental Health component, license #10778, had the following deficiencies found at the time of the survey:

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

Based on observation, record review, and interview the Assisted Living Facility failed to ensure that one out of 10 sampled residents met admission criteria (Resident #5).

Findings included:

The admission record revealed Resident #5 was re-admitted to the facility on from a local hospital after she had in the facility a few days before.

On at 8:45 AM Staff D stated that on at around 11:00 PM she was taking care of the 10 residents when all of the sudden she heard a big noise coming from Resident #5's she found resident laying on the floor. She stated that she picked the resident up and checked her to make sure that she was fine. The resident did not complaint about any pain. The following day around 6:30 AM, Staff D called resident's brother and explained what happened. The brother decided to take Resident #5 to the hospital. They found out that the resident had a broken hip.

On at 8:55 AM Resident #5's brother stated, " She used to walk not very well but she used to walk. Around two weeks ago she got up in the middle of the night to go to the she down. Staff D was working and was the one who found her on the floor and she informed me the following day and I took her to the hospital and she had an operation because she her hip."

A review of Resident #5's health assessment showed, diagnoses of , -dependent , ( ), . Special precautions was . Activities of Daily Living (ADL) assessment showed that the resident needed supervision with all of them. There was no documentation that hte facility sought assessment or treatment from a medical provider for the .

Hospital records received on showed Resident #5 was admitted on at 07:26 AM for hip pain/ . The resident was diagnosed with a of the left femur, of lesser with 4 cm fragment and right . The resident had surgery the following

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day and stayed in the hospital until . On at the time of discharge the hospital recommended to transfer the resident to a skilled nursing facility.

Class III

0009 - Admissions - Admission Package - 58A-5.0181(3) FAC; 400.0078(2)

Based on record review and interview the Assisted Living Facility failed to have resident's contract signed by Surrogate or Guardianship for one out of six sample residents (#6)

Findings include:

Record review of resident #6's revealed that resident was admitted on and the agreement, smoking policies and procedures, exit policy, rights as a resident to choose your health care provider, consent to release personal information, policy on reporting Medicaid fraud, refusal to follow therapeutic diet, bed hold policy, beneficiary designation form, acknowledgement of statement, storage of valuables policy, ALF policies, emergency contact, conflict of interest policy, & advance directives policy were not signed or dated by resident's Surrogate or Guardian.

On at 9:00 AM the Administrator stated that the Power of Attorney is on file but the daughter lives far away, and she had not come to the facility to sign the papers.

Class III

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

Based on interviews and record review, the facility failed to provide adequate supervision, care, or services to meet the needs of 2 of 10 sampled residents (Resident #4 and 5). Resident #4 eloped from the facility and was found hospitalized a day later. Resident #5 was observed in bed with a broken hip and she was not taken to the hospital until the following day.

Findings included:

1) A review of police, incident, and facility reports showed that on at 7:30 PM Resident #4 eloped from the facility and was found more than 12 hours later by a neighbor, who then called the police. The police took the resident to the hospital.

A review of hospital records showed Resident #4 was disoriented and , on admission. The resident

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also had a . A review of Resident #4's record showed, diagnoses of non- dependent, ( ), ( ), Moderate . Elopement risk was marked no, Activities of Daily Living (ADLs) were marked independent for ambulation, eating toileting and transferring, needs supervision for bathing, dressing, and self-care ( ).

On at 12:24 PM during a phone interview, Staff E stated that on the Sunday when the incident happened, she was working by herself as usual and Resident #4 said her son was outside waiting for her, as usual when he came to the facility to pick her up. Staff E stated she opened the door for Resident #4 and then kept taking care of the other residents. A few hours later, Staff E called the son to make sure that the resident was with him but he did not answer the phone. "I left a message, " She stated. "The following day, Monday, I called him back and he told me that his mother was not with him and that is when I informed the administrator/owner of what had happened and the he came to the facility and called the police.

A review of personnel records showed that there was none for Staff E, and there were no records documenting that the staff was trained to provide care and supervision to the residents.

On at 8:29 AM the Administrator stated that the resident went out between 7:00 PM and 7:30 PM on the previous Sunday and was found around the neighborhood by a person who called the police. The police took the resident to the hospital and she was there for one night. She returned to the facility the night of when her son brought her back.

On at 8:29 AM the Administrator stated, "Staff E called me the following morning, Monday, and I came to the facility and we looked everywhere in the neighborhood and we could not find her. We kept calling the son and left several messages and he called back Monday at 7:00 AM. He confirmed that she was not with him so then we did a police report. The son called me to let me know that she was in the Hospital."

On at 9:20 AM Resident #4's son stated during a phone interview that he usually goes to bed very early because he has to get up at 3:00 AM to go to work. On Monday morning when he got up at 3:00 AM he noticed that he had a missed call and a voice mail on his phone at 8:45 PM from Sunday. He listened the message that was left by Staff E asking if his mother was with him." The son reported, "I did not give it importance because the owner of the facility had not called me so I assumed that they found my mother." At around 7:00 AM on Monday, staff E called him back again asking if my mother was with me and I told her no. I asked her if she had informed this to the police and to the owner and she said 'no.' I told her that this was very important and she informed this to the owner and that is why

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the owner call the police and made the report. Later on Monday the hospital called me and told me that my mother was there. I called the owner and told him that my mother was found and she was in the hospital for a day." He further stated, "According to the hospital she was found by a neighbor the same Sunday night. My mother . down and the neighbor picked her up and offered her a glass of water. She asked her where did she live and she could not tell her thus the reason why the neighbor call the police and the police took her to the hospital."

Record review revealed that no incident report was filed for the the time that Resident #4 was gone, and her whereabouts were unknown.

On at 8:30 AM Resident #4 stated, "I have been living in this place for a long time already I think, I have a son that comes to see me and calls me. I do not remember exactly what happen because I forget things. I just know that I ended up in the hospital and my son went to pick me up and brought me here."

A review of the facility's elopement policy showed the following:
What to do in case a resident does elope: A. identify resident, B. search immediate area, C. advise police 911, D. inform facility administrator or person in charge, E. inform family, F. inform health care provider, G. search a large area, H. after 24 hours - file missing person report with police authority, and get Identification (ID) for the resident within 10 days if they showed elopement behavior. I. fill out adverse incident report 1-day and fax to AHCA in Tallahassee within 24 hours, J. fill out adverse incident report 15-days and fax to AHCA in Tallahassee after 15 days have passed since the incident.

A review of the facility record for Resident #4 showed that there was no documentation of an elopement assessment for the resident.

2) On at 8:45 AM Staff D stated that on at around 11:00 PM she was taking care of the 10 residents when all of the sudden she heard a big noise coming from Resident #5's . . . . she found resident lying on the floor. She stated that she picked the resident up and checked her to make sure that she was fine. The resident did not complaint about any pain. The following day around 6:30 AM, Staff D called resident's brother and explained what happened. The brother decided to take Resident #5 to the hospital . They found out that the resident had a broken hip.

On . . . . . at 8:55 AM Resident #5's brother stated, "My sister has been living in this place for six or seven months already. Around two weeks ago she got up in the middle of the night to go to the . . . . . she . down. Staff D was working and was the one who found her on the floor and she informed me the following day and I took her to the hospital and she had an operation because she

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her hip. I brought her back to this place, and she will have some for the next couple of weeks."

A review of Resident #5's health assessment showed, diagnoses of , non- -dependent , ( ), , . Special precautions was . Activities of Daily Living (ADL) assessment showed that the resident needed supervision with all of them. There was no documentation that the facility sought assessment or treatment from a medical provider for the .

Hospital records received on showed Resident #5 was admitted on at 07:26 AM for hip pain/ . The resident was diagnosed with of the left femur, of lesser with 4 cm fragment. Resident had surgery the following day and stayed in the hospital until . On at the time of discharge the hospital recommended to transfer the resident to a skilled nursing facility. Further review showed that the resident had a prior in 2017 where she sustained a nondisplaced of the left head.

Class II

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

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

Findings included:

On at 7:25 AM, observed Staff B and C were in the facility taking care of nine residents.

A review of the staff schedules revealed that the staff schedule posted on the board was for the month of , 2018.

On at 10:00 AM the administrator stated; "I know that the staff schedule is not up to date because I forgot to change it, I will do it immediately."

Class III

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

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Based on observation, record review and interview, the facility failed to have a current and approved fire inspection.

Findings included:

A review of facility records showed the facility had posted an expired fire inspection dated . . . . . .

On . . . . . the Administrator stated that he has been calling the fire inspector and left several messages but he had not come to the facility.

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 an adverse incident report with the state within one business day for two out of ten sampled residents. Resident #5 Eloped from the facility and resident #5 . down and suffer a broken hip (Resident #4 and 5).

Findings included:

1) Review of hospital and facility records showed that on . . . . . at 7:30 PM, Resident #4 eloped and she was missing from the facility. She was found more than 12 hours later. Resident#4 was found by a neighbor from the area and call the police. The police took the resident to the hospital.

2) Review of hospital and facility records showed that on . . . . . at 11:00 PM Resident #5 . down. The resident was hospitalized the following day and was found to have a broken hip.

A review of the incident report database and facility records revealed that no incident report was filed for either occurrence.

On . . . . . at 2:00 PM the Administrator stated that he tried to do the incident report for the resident who eloped but he did not have a user name or password, thus he had to request it.

Class III

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Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on observation, record review and interview, the facility failed to register one out of five sampled staff (E) on its roster and delete other one (C) in the background screening clearinghouse database.

Findings Included:

Employee record review showed Staff E, hired on was not on the roster. Staff C was hired on and stopped working on . Review of the background screening clearinghouse database showed the facility still had Staff C listed as an employee.

On at 10:15 AM the Administrator stated that he knew about this, but he was waiting for the consultant to come to the facility and update the roster.

Unclassified