STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968954	**08/14/2018**
NAME OF PROVIDER OR SUPPLIER **THE RESIDENCES OF UNITED HOMECARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **9355 SW 158TH AVE** **MIAMI, FL 33196**	

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

0000 - Initial Comments

A complaint survey (CCR# 2018011948) was conducted on and concluded on at The Residences of United Home care, License #12782. The facility had deficiencies at the time of the investigation.

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

Based on observation, interview and record review, the facility failed to provide the necessary care and services to meet the needs of 1 of 3 sampled residents assessed to require a therapeutic diet (Resident #1). Specifically, the facility failed to ensure staff followed dietary restrictions ordered by a healthcare provider. The facility also failed to ensure staff performed proficiently in an emergency situation and failed to communicate with the healthcare provider and family/responsible party regarding resident compliance with a therapeutic diet order. The resident choked while eating a sandwich provided by staff, and later .

The findings include:

Review of the facility's 15 day incident report to the Agency, dated indicated that the facility conducted an internal investigation into the events that occurred to Resident #1 on . Review of the report indicated that Resident #1 had been exhibiting restlessness and during the evening of , and into the morning of and she had been placed in the front lobby area to be monitored by an employee at the front desk. The report indicated that around 5:30 AM on , Resident #1 stated that she was hungry and requested a sandwich, and the staff gave her a ham and cheese sandwich and cranberry juice. The report indicated that at 6:05 AM, Resident #1 began eating the sandwich and choked. The report further indicated that the front desk employee began to perform the Heimlich maneuver on Resident #1. The employee called for assistance on the radio and called 911 when the resident became unresponsive. The report indicated that the front desk employee initiated ( ), and continued to perform with a nurse, who arrived on duty at 6:15 AM. The report indicated that police and Emergency ( ) personnel arrived and transferred Resident #1 to the nearest hospital for treatment. The report further indicated that Resident #1 had been taken off life support on and .

Review of the hospital records dated indicated Resident #1 arrived in the Emergency (ER) by 911 transport at 6:50 AM with the diagnosis of choking, and . Review of the ER physician assessment indicated Resident#1 was intubated, and remained in . The note indicated a history that Resident #1 was eating a sandwich when she began to choke.

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arrived on the scene at 6:21 AM and initiated the Lukas compression machine and intubated the resident, pulling a large amount food from her airway. The ER record indicated that Resident #1 was unresponsive, her pupils fixed and dilated, and with no spontaneous pulse. Resident #1 was admitted to the ( ) unresponsive, comatose, and intubated, being mechanically .

Review of Resident #1's health assessment form dated indicated diagnoses including dependent ( ), chronic kidney , and . Further review of the form indicated that Resident #1 required supervision with her activities of daily living (ADL) care. The form indicated that the resident was alert and oriented, ambulated with a rolling walker and was a risk. Resident #1's dietary requirements included a calorie controlled, no salt added, and mechanical soft diet.

Review of the progress notes for Resident #1 dated indicated that the resident was readmitted to the facility from a long term care nursing facility. The resident was assessed by the nursing staff to be alert and oriented but with and forgetfulness. Further review of the facility progress note dated indicated that Resident #1 was noted to be very , and unable to sleep. Review of the note indicated that at 9:00 PM Resident #1 returned from a scheduled psychiatrist visit and new medication orders to treat , were sent to the pharmacy to be filled.

In an interview with the Director of Clinical Services on at 10:45 AM she stated that on around 6:00 AM Resident #1 had eaten a ham and cheese sandwich, choked on it and became unresponsive, went into , requiring an emergency transfer to the ER. She stated that Resident #1 was a long term resident and had been readmitted from the nursing home on , with generalized and requiring a mechanical soft diet. She stated the resident had diagnoses of severe , and required visits to the psychiatrist to adjust her medications. The Director stated that a few days prior to , the resident was exhibiting an increase in behavior, hallucinations, pacing, and non- stop talking. The resident was non-combative and easily redirected, but seemed more agitated than normal for resident. She stated that she had obtained a physician order for urinalysis on . She stated that on in the evening Resident#1 was taken to the psychiatrist by her daughter and returned around 9 PM. The Director stated that medications orders were changed and sent to the pharmacy but that no new medications had been administered that evening. The Director stated that Resident #1 continued to exhibit restlessness after her return to the facility and the evening Medication Technician (Med tech) and staff were closely monitoring her behaviors. The nurse stated that during her investigation of the incident, she found that on at approximately 3 AM, the night Med tech had called Resident #1's daughter to notify her that the resident was very , talking a lot, and not sleeping. Resident #1 was allowed to speak with her daughter and this seemed to calm the resident.

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Resident #1's daughter requested that the resident not be sent to the hospital and stated she would be at facility early to check on her mother. The Director stated that for the resident's safety, the Med Tech positioned the resident in a wheelchair next to the front desk, where she sat talking to the security guard. The Director stated that between 4:30 and 5 AM Resident #1 expressed that she was hungry and the night Med Tech gave a caregiver a ham and cheese sandwich and cranberry juice to give to Resident #1. The Director stated that Resident #1 sat at front desk for approximately 1 hour before eating the sandwich. She stated that she had viewed the facility video from the morning of and observed Resident #1 at 6 AM start to eat the sandwich slowly, before she choked. The Director stated that she observed the security guard get up from the front desk and made attempts to perform the Heimlich maneuver on the resident. She stated that the guard was observed to radio for assistance, from two (2) Certified Nursing Assistant (CNA)s in the facility, working on higher floors, and he continued to perform the Heimlich maneuver. The Director stated that when the 2 CNAs arrived, Resident#1 became unresponsive, and staff moved her to the adjacent nursing station since other residents were in lobby watching. The Director stated that the guard and 2 CNAs were performing in the nurse's station when the facility nurse arrived on duty, after 6:00 AM. The Director stated that the day nurse connected equipment to check vital signs and went to get the automated external defibrillator ( ) unit in the hallway, at the same time a policeman was responding with an unit. The Director stated that the policeman and nurse continued to perform and attached the unit to Resident#1. personnel arrived on site and took over the code. The Director stated that Resident #1 never regained , and was unresponsive when transported via to hospital for treatment.

In an additional interview with the Director of Clinical Services on at 12:00 PM she stated that she was aware that Resident#1 was diagnosed with , , and had a diet order for mechanical soft diet. She stated that facility had been providing the diet as ordered, but the staff had informed her that the Resident #1's family would visit and bring food items from home. The Director stated that she had not notified the physician about the resident's noncompliance. The nurse stated that she was aware of the resident eating regular foods but was waiting to discuss the noncompliance with the health care provider later in month of , during a regularly scheduled visit. The Director stated that she was not aware if Resident #1's daughter was aware of the dietary restrictions. She further stated that all clinical staff have First Aid and training and they are expected to perform these skills when needed.

In an interview with the night Med Tech on at 4:15 PM she stated that Resident #1 was very , not sleeping, talking a lot, getting up pacing in her the evening of into morning of . The Med Tech stated that she was very concerned for Resident #1's safety and called the resident's daughter around 3 AM, to inform her of the increased behaviors and also have Resident #1 speak to her daughter. The Med tech stated that due to Resident #1's increased , and restlessness, she placed the resident in a wheelchair and positioned her near the front desk within

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sight of the security guard, since she needed to attend to other residents. She recalled around 4:30 AM, Resident #1 was expressing that she was hungry and asked for a sandwich. The Med Tech stated she gave a ham and cheese sandwich and cranberry juice to a CNA, to give to the resident. The Med Tech stated that she was not sure if Resident #1 had any dietary restrictions and she did not stay to watch the resident eat the sandwich. She stated that she went off duty at 6:00 AM and did not witness Resident #1 choking.

In an interview with the staff nurse on at 4:20 PM she stated that she was just coming on duty on at around 6:15 AM and observed Resident #1 on the floor of the nurses station with the security guard and CNA's performing . She stated Resident #1 was unresponsive and had food.

In an interview with the Administrator on at approximately 10:50 AM she stated that Resident #1 had history of and hallucinations which she was being treated for with medications. The Administrator stated that Resident #1 had been exhibiting increased , and , which caused the resident to be up all night pacing. She stated that on the evening of , and into the morning of , Resident #1 was observed , with , , and was talking non- stop. She stated that the facility staff had positioned the resident at the lobby front desk with the security employee, to provide constant monitoring of Resident #1. The Administrator stated that the lobby front desk is staffed by a facility employee during the day and evening shift, but during the night shift, the desk is staffed with an outside agency security guard. She stated that the guard is not a facility employee and had not completed facility training requirements. The Administrator stated that she had been informed that the security guard had been trained.

Review of the facility video footage of the incident that occurred on revealed footage time stamped 4:14 AM when Resident #1 was observed sitting in a wheelchair at the front desk and speaking to the security guard. Video time stamp at 5:24:48 reveals Resident#1 with a sandwich in her hand. Review of the video time stamped starting 6:02 AM until 6:09 AM revealed Resident#1 observed with a sandwich in her hands, taking bites from the sandwich, then asking the security guard for water. He handed her a water bottle and she took a drink. Immediately after taking a drink, Resident #1 was observed to reach her hand up to her chest. The video showed the security guard observing the resident then jumping up and running around the desk to assist her. At 6:10 AM the video showed him making numerous attempts to perform the Heimlich maneuver while Resident#1 remained in the wheelchair. Resident #1 was observed to be obese. The video showed the guard reaching for the walkie talkie radio and he appeared to call for assistance. The resident was observed to slump forward and did not respond. The video time stamped at 6:12 AM revealed the guard using his cell phone and facility CNA staff arriving off the elevators. Further observation of the video showed a

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CNA staff slapping Resident #1 on her back and then rubbing the resident's shoulders. The resident was slumped forward and remained nonresponsive at this point. The staff was observed standing behind the wheelchair, and no further attempts to perform emergency techniques were observed. At 6:13 AM, the staff were seen moving the resident in her wheelchair to the nearby nursing station. Numerous residents were observed standing around the incident, asking questions and refusing staff attempts to be redirected. The video time stamped at 6:16 AM showed the day nurse entering the facility and at 6:19 AM the police arriving, then personnel.

In an interview with the facility Director of Food Services on at approximately 12:15 PM he stated that he was the manager of the facility kitchen. He stated that he followed the therapeutic diet recommendations from the facility dietician of record and provided the policy for mechanical soft diet. When questioned about what snacks are available for the residents on a mechanical soft diet, he stated that a sandwich with soft bread, thinly sliced deli ham and cheese was acceptable under that diet. (see photo evidence of sample sandwich) He stated that the facility also provided peanut butter and jelly sandwiches, sugar free applesauce, sugar free jello and sugar free yogurt as snacks anytime. He stated that residents on a mechanical soft diet were allowed thin sliced deli ham and cheese, and this was not a safety issue on a mechanical soft diet. He stated that the meat did not need to be cut into smaller pieces.

Review of the facility "Diet Manual" indicated the definition of a mechanical soft diet is designed for people who have difficulty chewing and swallowing. It was designed to minimize amount of chewing necessary to ingest food and to increase the ease of swallowing. Chopped, ground and pureed foods were included in this diet, as well as foods that readily break apart without a knife. Review of the policy indicated meal planning guidelines including "meats are ground to the consistency of ground meat".

In an interview with the corporate dietician on at 4:35 PM she stated that she was the corporate registered dietician and did not get involved with daily menus but worked closely with the facility providing seminars for the residents. When she was questioned about the dietary menu term of "Mechanical Soft" diet, she stated that the diet was somewhat broad and depended on the individual resident's diagnosis and status. She stated that routinely the diet recommended foods to be soft and chopped into smaller bite size pieces, so the resident could swallow safely and the food item must not be too dry. She stated that in her professional opinion the condition of could improve but before any change to menu was made, she recommended that the resident's swallowing should be reassessed by the Speech She stated that only the Speech could determine a resident's current swallowing status and recommend a modification/change to the diet.

In an interview with Resident #1's daughter on at 9:54 AM she stated that her mother had

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lived at the facility for 3 years and had diagnoses including , , and , conditions. She stated that her mother had recently been readmitted to the facility from a skilled nursing facility on , after her mother experienced a decline in medical condition and . She stated that while at the nursing home, her mother had been seen by a Speech , and a swallowing study conducted, revealing a diagnosis of , , . The daughter stated that she was aware of the recommended dietary restrictions of a mechanical soft diet and was concerned that when her mother was readmitted to the assisted living facility she would be provided the correct diet. She stated that she recalled observing her mother eating a sandwich at the nursing home, which consisted of paste- like meat. She stated that since her mother was readmitted to the facility in , she was aware of the diet restrictions and had not brought any food from home to her mother. She stated that she never saw her mother choke while eating and was upset that facility had given her mother a ham and cheese sandwich.

In an interview with Resident #1's physician on at 11:40AM he stated that he recalled visiting the resident on after the resident had been readmitted from the nursing home. He stated that he could not recall if the resident had any dietary restrictions, but stated that if the resident assessment that was completed by the nursing home included dietary recommendations /restrictions, they should be followed by the facility. He stated that he could not recall any notification from the facility regarding any resident dietary noncompliance concerns. He stated that any concerns with swallowing should be properly evaluated by a speech , before any dietary changes were made.

Class II

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0000 - Initial Comments

A complaint survey (CCR# 2018011948) was conducted on and concluded on at The Residences of United Home care, License #12782. The facility had deficiencies at the time of the investigation.

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

Based on observation, interview and record review, the facility failed to provide the necessary care and services to meet the needs of 1 of 3 sampled residents assessed to require a therapeutic diet (Resident #1). Specifically, the facility failed to ensure staff followed dietary restrictions ordered by a healthcare provider. The facility also failed to ensure staff performed proficiently in an emergency situation and failed to communicate with the healthcare provider and family/responsible party regarding resident compliance with a therapeutic diet order. The resident choked while eating a sandwich provided by staff, and later .

The findings include:

Review of the facility's 15 day incident report to the Agency, dated indicated that the facility conducted an internal investigation into the events that occurred to Resident #1 on . Review of the report indicated that Resident #1 had been exhibiting restlessness and during the evening of , and into the morning of and she had been placed in the front lobby area to be monitored by an employee at the front desk. The report indicated that around 5:30 AM on , Resident #1 stated that she was hungry and requested a sandwich, and the staff gave her a ham and cheese sandwich and cranberry juice. The report indicated that at 6:05 AM, Resident #1 began eating the sandwich and choked. The report further indicated that the front desk employee began to perform the Heimlich maneuver on Resident #1. The employee called for assistance on the radio and called 911 when the resident became unresponsive. The report indicated that the front desk employee initiated ( ), and continued to perform with a nurse, who arrived on duty at 6:15 AM. The report indicated that police and Emergency ( ) personnel arrived and transferred Resident #1 to the nearest hospital for treatment. The report further indicated that Resident #1 had been taken off life support on and .

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Review of the progress notes for Resident #1 dated indicated that the resident was readmitted to the facility from a long term care nursing facility. The resident was assessed by the nursing staff to be alert and oriented but with and forgetfulness. Further review of the facility progress note dated indicated that Resident #1 was noted to be very , and unable to sleep. Review of the note indicated that at 9:00 PM Resident #1 returned from a scheduled psychiatrist visit and new medication orders to treat , were sent to the pharmacy to be filled.

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Resident #1's daughter requested that the resident not be sent to the hospital and stated she would be at facility early to check on her mother. The Director stated that for the resident's safety, the Med Tech positioned the resident in a wheelchair next to the front desk, where she sat talking to the security guard. The Director stated that between 4:30 and 5 AM Resident #1 expressed that she was hungry and the night Med Tech gave a caregiver a ham and cheese sandwich and cranberry juice to give to Resident #1. The Director stated that Resident #1 sat at front desk for approximately 1 hour before eating the sandwich. She stated that she had viewed the facility video from the morning of and observed Resident #1 at 6 AM start to eat the sandwich slowly, before she choked. The Director stated that she observed the security guard get up from the front desk and made attempts to perform the Heimlich maneuver on the resident. She stated that the guard was observed to radio for assistance, from two (2) Certified Nursing Assistant (CNA)s in the facility, working on higher floors, and he continued to perform the Heimlich maneuver. The Director stated that when the 2 CNAs arrived, Resident#1 became unresponsive, and staff moved her to the adjacent nursing station since other residents were in lobby watching. The Director stated that the guard and 2 CNAs were performing in the nurse's station when the facility nurse arrived on duty, after 6:00 AM. The Director stated that the day nurse connected equipment to check vital signs and went to get the automated external defibrillator ( ) unit in the hallway, at the same time a policeman was responding with an unit. The Director stated that the policeman and nurse continued to perform and attached the unit to Resident#1. personnel arrived on site and took over the code. The Director stated that Resident #1 never regained , and was unresponsive when transported via to hospital for treatment.

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CNA staff slapping Resident #1 on her back and then rubbing the resident's shoulders. The resident was slumped forward and remained nonresponsive at this point. The staff was observed standing behind the wheelchair, and no further attempts to perform emergency techniques were observed. At 6:13 AM, the staff were seen moving the resident in her wheelchair to the nearby nursing station. Numerous residents were observed standing around the incident, asking questions and refusing staff attempts to be redirected. The video time stamped at 6:16 AM showed the day nurse entering the facility and at 6:19 AM the police arriving, then personnel.

In an interview with the facility Director of Food Services on at approximately 12:15 PM he stated that he was the manager of the facility kitchen. He stated that he followed the therapeutic diet recommendations from the facility dietician of record and provided the policy for mechanical soft diet. When questioned about what snacks are available for the residents on a mechanical soft diet, he stated that a sandwich with soft bread, thinly sliced deli ham and cheese was acceptable under that diet. (see photo evidence of sample sandwich) He stated that the facility also provided peanut butter and jelly sandwiches, sugar free applesauce, sugar free jello and sugar free yogurt as snacks anytime. He stated that residents on a mechanical soft diet were allowed thin sliced deli ham and cheese, and this was not a safety issue on a mechanical soft diet. He stated that the meat did not need to be cut into smaller pieces.

Review of the facility "Diet Manual" indicated the definition of a mechanical soft diet is designed for people who have difficulty chewing and swallowing. It was designed to minimize amount of chewing necessary to ingest food and to increase the ease of swallowing. Chopped, ground and pureed foods were included in this diet, as well as foods that readily break apart without a knife. Review of the policy indicated meal planning guidelines including "meats are ground to the consistency of ground meat".

In an interview with the corporate dietician on at 4:35 PM she stated that she was the corporate registered dietician and did not get involved with daily menus but worked closely with the facility providing seminars for the residents. When she was questioned about the dietary menu term of "Mechanical Soft" diet, she stated that the diet was somewhat broad and depended on the individual resident's diagnosis and status. She stated that routinely the diet recommended foods to be soft and chopped into smaller bite size pieces, so the resident could swallow safely and the food item must not be too dry. She stated that in her professional opinion the condition of could improve but before any change to menu was made, she recommended that the resident's swallowing should be reassessed by the Speech She stated that only the Speech could determine a resident's current swallowing status and recommend a modification/change to the diet.

In an interview with Resident #1's daughter on at 9:54 AM she stated that her mother had

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968954	**08/14/2018**
NAME OF PROVIDER OR SUPPLIER **THE RESIDENCES OF UNITED HOMECARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **9355 SW 158TH AVE** **MIAMI, FL 33196**	

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

lived at the facility for 3 years and had diagnoses including , , and , conditions. She stated that her mother had recently been readmitted to the facility from a skilled nursing facility on , after her mother experienced a decline in medical condition and . She stated that while at the nursing home, her mother had been seen by a Speech , and a swallowing study conducted, revealing a diagnosis of , , . The daughter stated that she was aware of the recommended dietary restrictions of a mechanical soft diet and was concerned that when her mother was readmitted to the assisted living facility she would be provided the correct diet. She stated that she recalled observing her mother eating a sandwich at the nursing home, which consisted of paste- like meat. She stated that since her mother was readmitted to the facility in , she was aware of the diet restrictions and had not brought any food from home to her mother. She stated that she never saw her mother choke while eating and was upset that facility had given her mother a ham and cheese sandwich.

In an interview with Resident #1's physician on at 11:40AM he stated that he recalled visiting the resident on after the resident had been readmitted from the nursing home. He stated that he could not recall if the resident had any dietary restrictions, but stated that if the resident assessment that was completed by the nursing home included dietary recommendations /restrictions, they should be followed by the facility. He stated that he could not recall any notification from the facility regarding any resident dietary noncompliance concerns. He stated that any concerns with swallowing should be properly evaluated by a speech , before any dietary changes were made.

Class II