STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965068	**08/03/2018**
NAME OF PROVIDER OR SUPPLIER **CARING HEARTS ASSISTED LIVING INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8601 SW 36 STREET** **MIAMI, FL 33155**	

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

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

Based on observations, record review, and interviews, the facility exceeded its licensed capacity of six beds. The facility had a census of seven residents that were receiving housing, meals, and assistance with activities of daily living.

Findings included:

During a facility tour on . . . . . at 6:08 AM, Resident #7 was observed sleeping on a hospital bed with half side rails with a recliner in front of the bed. At 6:15 AM Staff B stated "Resident #7 is in day care. The family works during the night and brings Resident #7 here to spend the night."

During an interview on . . . . . at 4:15 PM, the Administrator stated "no I don't have any record for Resident #7 here because she is in day care, and her family member is in charge of that. I only have the medications here because her family member is not in town at the moment. That is why you found her sleeping here. The doctor who sees her is the same doctor for our place."

A review of Resident #7's record on . . . . . from the Home Health Agency revealed that the Home health record's home health aide care plan dated . . . . . had the same address as the facility. Resident #7 had been receiving services from the home health agency from . . . . . to . . . . . at the facility.

Unclassified

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0000 - Initial Comments

On , 2018 through , 2018 a Biennial Re-licensure Survey was conducted at Caring Hearts Assisted Living Inc (license # 9661). Deficient practices were identified at the time of the survey:

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on observation, record review and interview, the facility failed to provide documentation of a health assessment for one out of seven sampled residents (Resident #7).

Findings included:

On at 6:08 AM, Resident #7 was observed sleeping on a hospital bed with half side rails with a recliner in front of the bed.

At 10:38 AM a home health nurse was observed administrating medications to Resident #7.

A review of the Resident #7's file on , revealed that the facility did not have a health assessment available for a review for Resident #7.

During an interview on at 9:46 AM, the Administrator stated "Resident #7 is a day care resident."

Class III

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

Based on observation, record review, and interview, the facility failed to provide care and services appropriate to the needs of resident of one out of seven sampled residents accepted for admission to the facility (Resident #7).

Findings included:

During the facility's tour on at 6:08 AM, Resident #7 was observed sleeping on a hospital bed with half side rails with a recliner in front of the bed. At 6:15 AM Staff B stated "Resident #7 is in day care. The family works during the night and brings Resident #7 here to spend the night."

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On at 9:46 AM the Administrator stated "Resident #7 is a day care resident.

A review of the admission and discharge log revealed that Resident #7 was not on the facility's admission and discharge log. Resident #7 had no contract for residency, no documentation form the family and no health assessment.

A review of the day care log on revealed that Resident #7 was admitted to the facility as a Day Care Resident on and was to attend from 6 AM to 7 PM.

At 9:52 AM on Residents #7' morning and bedtime medications were found in the medication . The morning medications 325 mg, , 81 mg, /D 600 mg, , 75 mg tablet, Isosorb Mono tablet 30 mg ER, Losatan POT tablet 100 mg, , suc tablet 50 mg ER, g, E cap 1000 UI, , 10 mg, and Tablet 5 mg were still in the pack.

On at 10:25 AM observed Staff A walked in the facility. The home health nurse stated "I am here for Resident #7 for medications, and for Resident #4 and #5 for . I have been coming here for two or three months more or less. I did not come for 2 days. I come today, I don't know who came to replace me."

On at 10:31 AM the home health nurse was observed walking to the medication's , took Resident #7's medication basket and then preparing Resident's #7 medications without having any medical orders. At 10:38 AM the home health nurse was observed administering medications to Resident #7. At 10:58 AM The home health nurse was observed signing the MOR. A review of the MOR revealed that bedtime medications 325 mg, tablet 5 mg, , 25 mg, and , Capsule 15 mg were not given on and the home health nurse signed for 325 mg tablet given on at 8:00 PM. Also, , Cap 15 mg was initialed on in the MOR as administrated, but the medication was in the pack. The home health nurse also signed the MOR at 10:58 AM for 8 am Medications.

At 11:34 AM on observed Resident #7 appeared to be . The resident couldn't hold her head up. Staff B and C were trying to wake Resident #7 up by calling her and touching her. They then transferred the resident on a wheelchair and Staff B had to hold the resident's head and the resident feet were dragging on the floor. At 11:36 AM Staff B stated "the resident is just sleeping." At 11:40 AM Staff B returned with the resident on the wheelchair and placed her on a recliner. The resident was observed to be still , over/sedated, could not still hold up her head. Staff C brought a cup of water and forced the resident to drink. At 11:54 AM Staff F came back to the facility, spoke to the resident and stated "she

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is okay, when she takes the medications she asleep right after. She is relaxed. In this moment she opened the eyes and she response. In this moment she tells me she is good."

During an interview On at 4:15 PM, the Administrator stated "no I don't have any record for Resident #7 here because she is in day care, and her family member is in charge of that. I only have the medications here because her family member is not in town at the moment. That is why you found her sleeping here. The doctor who sees her, it is the same doctor for our place." At 4:18 PM the Administrator stated "Yes, I have a contract, but she is day care. Really I never put the money I receive for her in the Income and Expense book." The administrator went through the daycare book and stated "I don't have it here. It is done, but it is in the main office."

On at 4:08 PM during an interview with the Home Health Agency Administrator stated "Resident #7 was discharged from the Home Health Agency since , 2018. I don't know what record you are asking for and I have to speak to the administrator because she was discharged."

A review of Resident #7's record on from the Home Health Agency revealed that the Home health record's prescription for the referral was received on . Additionally, the home health aide care plan dated had the same address as the facility. Resident #7 had been receiving services from the home health agency from to at the facility.

On at 9:22 AM during an interview the Home Health Agency Administrator stated "the patient was with the agency from , to 26. We don't have any prescription for this patient at this moment. I need to speak to the nurse because we don't know why she was giving medication. The nurse works for me, but we have two other patients at this facility. She supposed to be giving to two people. I don't know why she was giving medications there."

Class III

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

Based on observation and interview, the facility failed to treat one out of seven sampled residents with respect, free of retraints (Resident #7).

Findings included:

During the facility's tour on at 6:08 AM, Resident #7 was observed sleeping on a hospital bed with half side rails and there was a recliner in front of the bed.

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During an interview on at 6:16 AM Staff B stated "the chair is to prevent Resident #7 from falling."

Class III

0031 - Resident Care - Third Party Services - 58A-5.0182(7) FAC

Based on record review and interview, the facility failed to ensure that hospice documentation was in the facility for services provided to three out of seven sampled residents (Resident #1, #2, and #3).

Findings included:

A review of Resident #1, #2, and #3' file on revealed that the residents' last three hospice plans of care were dated , , and . The facility did not have a hospice certification or a hospice recertification in file for the residents.

During an interview on at 12:50 PM, the Administrator stated "I don't know where the certification is at."

Class III

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

Based on record review and interview, the facility failed to maintain a daily medication observation record (MOR) for one out of seven sampled residents who received assistance with self-administration of medications (Resident #5).

Findings included:

Medication reconciliation on revealed that 180 mg was not given to the resident.

A review of the MOR on revealed that Staff B initialed that the medication was given to Resident #5.

During an interview on at 8:38 AM the Administrator went through the MOR and stated "this is , let me go find it." Then, the Administrator brought an unlabeled OTC and stated "Staff B is going

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to give it to the resident now."

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on record review and interview, the facility failed to have prescriptions orders on file for one out of seven sampled residents (Resident #7).

Findings included:

On at 9:50 AM, observed in Resident #7 medication basket: 325 mg, 81 mg, /D 600 mg, 75 mg tablet, Isosorb Mono tablet 30 mg ER, Losatan POT tablet 100 mg, suc tablet 50 mg ER, g, E cap 1000 UI, 10 mg, and Tablet 5 mg. A review of the facility records showed no medication orders for these items.

During an interview on at 9:58 AM, the Administrator stated "Resident #7's family member brought the medications because he was going to be out today."

Class III

0057 - Medication - Over The Counter (OTC) Products - 58A-5.0185(8) FAC

Based on observation and interview, the facility failed to maintain all medication centrally stored.

Findings included:

Medication reconciliation on revealed that 180 mg was not in Resident #5's medication basket.

A review of the MOR (Medication Observation Record) on revealed that Staff B initialed that the medication was given to Resident #5.

During an interview on at 8:38 AM the Administrator went through the MOR and stated "this is , let me go find it." Then, the Administrator brought an unlabeled OTC relief 180 mg and stated "Staff B is going to give it to the resident now."

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Class III

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

Based on observation, record review and interview, the facility failed to have evidence of a negative examination, documented on an annual basis, for two out of five sampled staff (Staff A and B).

Findings included:

On at 6:05 AM, Staff B was found alone in the facility with a census of seven residents. At 7:00 AM Staff B was observed assisting the residents with self-administration of medications.

Record review of the facility's personnel file on revealed that there was no documentation of a negative examination available to review for Staff A, hired on and Staff B, hired on .

During an interview on at 4:18 PM, the Administrator went through the files and stated "ok."

Class III

0083 - Training - First Aid and - 58A-5.0191(5) FAC

Based on observation, record review, and interview, the facility failed to have an updated first aid and ( ) in file for one out of five sampled staff (Staff B). Also, the facility failed to have documentation of training for one out of five sampled staff (Staff C).

Findings included:

On at 6:05 AM, Staff B was found alone in the facility with a census of seven residents. At 6:16 AM Staff C arrived at the facility and started assisting the residents with .

A review of the facility's personnel file on revealed docuemntation that Staff B, hired on , had a training dated - (expired). Also, the facility did not have documentation of training for Staff C, hired on .

During an interview on at 4:18 PM, the Administrator went through the employees' files, acknowledged and stated "ok" for the missing documentation.

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Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC

Based on record review and interview, the facility failed to provide to five out of five sampled staff a minimum of 6 hours training on providing assistance with self-administration of medications and safe medication practices in an assisted living facility (Staff A, B, C, D, and E).

Findings included:

A review of the facility's personnel records on , revealed that Staff A had 2 hours training providing assistance with self-administered medications and safe medication practices documentation in file dated ; Staff B had 2 hours training dated and 2 hours dated ; Staff C had 4 hours training dated ; and Staff D had 2 hours training dated .

During an interview on at 4:18 PM, the Administrator went through the employees' files, acknowledged the deficient practice and stated "ok".

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation, record review, and interview, the facility failed to follow a meal planned based on the current USDA Dietary Guidelines and the facility's menu.

Findings included:

On at 7:05 AM the residents's breakfast was observed to be Milk and coffee, toast with margarine, water.

A review of the facility's menus on stated "Assorted juices 4 oz, Dry cereal ¾ cup or hot cereal ½ cup, bread 1 slice, margarine 1 t, milk 8 oz. The menus were not followed.

During an interview on at 4:18 PM, the Administrator stated "the residents refuse to eat the cereal. The person in the kitchen is in charge to cross it out or put the change."

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Class III

0120 - Fiscal - Financial Stability - 429.17(3) FS: 429.275(1)58A-5.021(1) FAC

Based on record review and interview, the facility failed to maintain income and expense records.

Findings included:

A review of the facility's income and expense log revealed that the facility did not have complete financial records. The facility did not list Resident #7's monthly payment on the log.

During an interview on at 4:18 PM, the Administrator stated "Really, I never put the money I receive for Resident #7 in the Income and expense book."

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on record review and interview, the facility failed to have a complete and accurate application in file for one out of five sampled staff (Staff C).

Findings included:

A review of the facility's personnel file on revealed an application dated for Staff C, hired on the same date with no refererences.

During an interview on at 4:18 PM, the Administrator went through the employees' files, acknowledged and stated "ok".

Class III

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

Based on observation, record review, and interview, the facility failed to have a complete record for one out of seven sampled residents (Resident #7). The facility also failed to have an accurate health assessment for two out of seven sampled residents (Resident #1 and #2).

Findings included:

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During the facility's tour on at 6:08 AM, Resident #7 was observed sleeping on a hospital bed with half side rails with a recliner in front of the bed.

A review of the facility's day care log on revealed that Resident #7 was admitted to the facility as a Day Care Resident on and was to attend from 6 AM to 7 PM.

A review of the facility's file on revealed that Resident #1's plan of care dated , , and stated " on sacrum". A review of the resident's medical orders dated stated "puree diet for ." A review of Resident #1's Health Assessment dated did not list as a diagnosis and did not reflect that the resident had a .

A review of the facility's file on revealed that Resident #2's medical orders dated stated "puree diet for in file dated . A review of Resident #2's health assessment dated revealed that was not listed as a diagnosis.

During an interview on at 6:15 AM Staff B stated "Resident #7 is in day care. The family works during the night and brings Resident #7 here to spend the night."

On At 9:46 AM the Administrator stated "Resident #7 is a day care resident.

Class III