STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969065	**09/14/2018**
NAME OF PROVIDER OR SUPPLIER **SHARON'S SENIOR SERVICES, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2270 NW 64TH ST** **MIAMI, FL 33147**	

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

0000 - Initial Comments

A Standard Biennial survey was conducted at Sharon's Senior Services, Inc. from . . . . to . . . . .
The facility had deficiencies found at time of the survey.

0004 - Licensure - Requirements - 58A-5.016 FAC

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

Findings included:

Record of the facility's inspections revealed that the health inspection expired on .

Observation on at 9:00 am revealed Staff B searched through the documents, but she could not find an update health inspection. Next, Staff B called Staff A to find an update health inspection.

Interview on . . . . at 9:30 am Staff B stated, "I could not find it."

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 ensure that one of six sampled . . . . residents that was admitted to the facility received care and services to meet their needs. As a result, Resident #2 was placed at risk of serious harm by not receiving ordered medications which included daily . . . . The facility also failed to maintain a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, or other changes that resulted in the provision of additional services for one of six (#2) sampled Residents.

Findings included:

Observation on . . . . . at 9:00 am revealed a plastic box inside of the refrigerator with three . . pens which belonged to Resident #2. Further observations on at 9:05 revealed Resident #2 had a plastic box with several empty bottles (10) of medications. There were two bottle of medications (50 mg and , , 5 mg) with a few pills inside. Staff B stated, "Resident #2 is not taking any medications."

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Review of Resident #2's record revealed the facility did not have daily medication observation records (MORs) for her since admission to the facility on .

Interview on at 9:00 am Staff B stated, "Resident #2 is not taking anymore; she stopped taking . The pens are empty." On at 9:05 am Staff B stated, "Resident #2 had an old MOR in her record." Resident #2 searched through the facility previous MORs but Resident #2 did not have any MORs.

Record review revealed Resident #2 did not have a completed record at the facility with included changed in the resident's condition or medications and hospitalization. Resident #2's health assessment dated stated, "Type 2 , , , , , , , and ." Health assessment stated that Resident #2 had Chronic Kidney (-4). In addition, health assessment reflected that Resident #2's diet as , low salt and low fat. Resident #2 needed assistance with self-administration of medication, and she had a right upper and lower extremity . Resident #2's health assessment documented the following medications: , 5 mg, , 81 mg, , 12.5 mg, 1 mg, 17 units, 1 tab, Rosvastatin 10 mg, 50 mg, D 0.1 ml and 150 mg). Record review revealed that Aripiprozole 5 mg and 50 mg were not part of the list of the medications for Resident #2's health assessment and/or hospital record.

Interview on at 12:41 pm Resident #2 stated that she moved to the facility on , and she had not seen a doctor while she had been living in the facility because she had no insurance. Resident #2 stated that a month ago, she went to the hospital because she was outside, and she felt overheated. Resident #2 stated that her started racing , and she felt weak and overheated. Resident #2 stated that she was at the Hospital a month ago.

Interview on at 12:41 pm Resident #2 stated that she was at the hospital and her sugar was high, such as, 500 and 400. Resident #2 stated that the hospital recommended her to take the daily, but she was not taking because she did not have any. However, Resident #2 stated that she was taking . Resident #2 stated she did not have a doctor; she had not seen a doctor since last time she went to the hospital, and she hoped to fix her insurance situation.

Interview on at 12:46 pm, Resident #2's daughter in law stated that Resident #2 had been living in the facility since of this year. Resident #2 was dependent, but she had no health insurance coverage. The Daughter in Law stated, Resident #2 was still on , and she was not taking . Resident #2 did not have a nurse to provide her because she had no health insurance; therefore, she did not have that service. The facility was administering the for

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Resident #2 because Resident #2 did not know how to do it. The facility was giving her . She had no doctor, and she had not been assessed by a doctor yet. In addition, the Daughter in law stated that Staff A was doing all the diligence to get approval of a Program for Resident #2 for her and medications.

An interview on at 1:00 pm, Staff B stated, "Resident #2 was not taking because she did not have health insurance coverage. Resident #2 had no medications at all; she was not taking medications since a month ago. She did not have or . We kept the empty bottles because Resident #2 liked to keep them there. Resident #2 moved to the facility from a Hospital. Staff B indicated that Resident #2 used to have VA insurance coverage because her husband was a Veteran. However, her husband's insurance covered expired, and Resident #2 had no health insurance any more. Staff B stated that Resident #2 went back to the hospital a month ago because she was feeling overheated. Staff B stated that she thought that Resident #2 sat outside for a while under the hot sun, and she became overheated. She went to the hospital by ambulance. Staff B only mentioned Resident #1's hospitalization from - , however, Staff B did not mention the hospitalization from - .

Interview on at 1:29 pm Staff A revealed Resident #2 did not have health insurance to cover medication and home health services. Staff A stated that she was working to help Resident #2 to get health insurance with the help of her daughter in law, too. Staff A stated that Resident #2 received $1,150.00 monthly. However, Resident #2 had no coverage for her medications.

Hospital record review for Resident #2 reflected the following information, "A female arrives to the hospital on by the Rescue. Patient presented to the emergency department with left leg numbness x 6 hours ago associated with Syncopal episode, , , arm pain, neck pain and back pain." Hospital documents stated that Resident #2 alleged the following information, "Resident #2 went to bed at 11:00 pm last night, and she was fine. When she woke up this morning at 5:00 am, she was . Patient fainted in the shower at 7:00 am today. Patient medical history of kidney failure, . Patient has a left arm . Chief complaint description as admitted diagnosis as , Hyperkalemia, Failure, and ."

Resident #2's hospital documents stated, "History of present illness: The patient presents with . The onset was 5 hours ago. The course duration of symptoms is constant. The character of symptoms is numbness. The degree at present is moderate. Risk factors consist of , , and . Left leg numbness x 6 hours ago. A CT head showed atrophy and small vassal changes, clinical correlation and follow up is needed. Medications notice as , 81 mg, 20 mg, Lantus Pen 100 unit, Lispro 100 units, and ,

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10 mg."

Resident #2 went to the hospital on , and the hospital documents stated, "A female comes into the Emergency Department with generalize this morning. Admitted at the hospital on at 22:56 to inpatient telemetry unit. Patient reports that she experienced a near event earlier today due to symptoms. Patient has a history of . Patient was seen in the Emergency Department last month for similar symptoms/diagnose with , Hyperkalemia and Failure." Hospital documents reflected, "The patient has the following diagnosis confirms: and . Patient presents , Electrolyte Imbalance, Accident and .

Hospital record review showed, "An electro on reflect rate 79 Rhythm in left anterior fascicular , (QRS interval right) . On at 20:05 patient's X-ray first view, reflect poor inspiratory to a small infiltrate or , which needs follow up. There is poor inspiratory effort. Based on a reading of mmHg in the Emergency Department, along with the patients' existing , I recommend that the patient call their PCP or a Physician of their choice in the next two weeks to arrange follow up for further evaluation. The patient has also been advised to monitor their , at home and to keep a regular log or recording of , measurements to show their PCP. They understand this verbalization."

Interview on at 1:55 pm Staff A stated that Resident #2 did not qualify for Medicaid due to her income and assets. They sent Resident #2 to the hospital twice and confirmed that Resident #2 had not seen a doctor outside of the hospital since being admitted to the facility. Staff A confirmed that Resident #2 was , and that she checked Resident #2 sugar levels. However, the facility did not have any records of the resident's sugar levels since admission.

Date??Interview at 1:58 pm Staff B stated, " I could not find Resident #2's sugar log, I will take Resident #2 sugar level now, and I will recorded in a new paper."

Observation on at 2:00 pm revealed Staff B took Resident #2's sugar and recorded it as 277. The facility agreed to take Resident #2 to the hospital because she did not have and/or medication to keep her sugar stable.

On at 8:30 pm, observation found Resident #2 was in the facility and had not received any medical treatment from a health care provider.

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Class II

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

Based on record review and interview, the facility failed to maintain an accurate, up-to date medication observation records (MORs) for 4 of 5 (3, 4, 5 and 6) sampled residents.

Findings included:

Record review revealed Resident #3's medications (, 81 mg, , 25 mg, 100 mg, and more) did not have initials as given from 8th - 9th of 2018 for the morning and night dosage.

Record review revealed Resident #4's medications (, , 5 mg, Dred , 100-25 mcg, 20 MG, and 30 mg) did not have initials as given from 8th - 9th of 2018 for the morning and night dosage.

Record review revealed that Resident #5's medications (, 81 mg, , 50 MCG, Polyethylene , , D3 2,000 unit, 8.6 mg, and more) do not have initials as given from 8th -9th of 2018 for the morning and night dosage.

Record review revealed that Resident #6's medications (0.4 mg, , 81 mg, 5 mg, Succ ER 25 mg, and more) do not have initials as given from 8th - 9th of 2018 for the morning and night dosage.

Interview on at 9:30 am Staff B stated, "The previous staff forgot to sign the medication observation records; Staff A always emphasize to sign the medications, as soon as possible, the Residents have their medications."

Class III

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

Based on observation and interview, the facility failed to keep all medications in a locked cabinet, locked cart, or other locked storage receptacle, or area at all times for one of six (#1) sampled residents.

Findings included:

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Observation on at 8:50 am showed the medication inside the refrigerator was unlocked for Resident #1.

During an interview on at 8:50 am, Staff B acknowledged that the medications were unlocked and belonged to Resident #1. Staff D reported, "Staff B said we used to have a lock in the refrigerator door, but we remove it." In addition, Staff D stated, "I will talk with Staff A to keep medications lock without locking the refrigerator."

Class III

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

Based on record review and interview, the facility failed to provide evidence of a negative examination on an annual basis for one of four sampled staff (Staff A).

Findings included:

Record review revealed Staff A did not have an update statement on file. The facility failed to provide evidence of a negative examination on an annual basis for Staff A. The last examination expired on .

Interview on at 1:00 pm Staff B acknowledged Staff A needed to update her examination."

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 have updated medication training for four of four (Staff A, B, C and D) sampled staff.

Findings included:

Record review revealed that the facility did not have documentation that Staff A (hired) received the new medication training. Staff A's last training dated .

Record review revealed that the facility did not have documentation that Staff B (hired) received the new medication training. Staff B's last training dated .

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Record review revealed that the facility did not have documentation that Staff C (hired) received the new medication training. Staff C's last training dated .

Record review revealed that the facility did not have documentation that Staff D (hired) received the new medication training. Staff D's training dated .

Interview on at 1:00 pm Staff B acknowledged that staff needed to take the new medication training.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility failed to provide a safe living environment.

Findings included:

Observation on at 9:00 am showed two big boxes (one with a generator) in a corner, next to the dining area. The dining area had seven broken chairs. A while chair at the entrance of the facility with a box next to a white sit. A blue mattress bend next to the entrance of the facility. In addition, three boxes next to the sofa (living area), and the facility needed to mop the floor.

Interview on at 1:00 pm Staff B stated, "I will tell Staff A about this boxes."

Class III

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

Based on observation, record review, and interview, the facility failed to have an up-to-date admission and discharge log.

Findings included:

Observation on at 8:00 am revealed the facility had six residents.

Record review (admission/discharge log) revealed that the facility had seven Residents. Further record review revealed that Resident #7 was no longer living in the facility.

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Interview on [redacted] at 9:00 am Staff B stated, "Resident #7 is no longer living in the facility. I will tell Staff A to discharge Resident #7 from the admission/discharge log.?

Class III

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

Based on record review and interview, the facility failed to have daily [redacted] administration records for one of six sampled residents (#2). The facility failed to have a consent for an unlicensed staff to assist with self-administration of medication for two of six sampled Residents (#2 and #3).

Findings included:

Record review revealed Resident #3's medications observation records signed by unlicensed staff from [redacted] - [redacted]. However, Resident #3 did not have a signed consent for an unlicensed staff to assist with self- administration of medication.

Record review revealed that Resident #2 did not have a signed consent for an unlicensed staff to assist with self- administration of medication.

Interviewed on [redacted] at 9:00 am, Staff B acknowledged that she assisted Resident #2 with his daily medication, and Resident #2 did not have in his file a consent to assist with self-administration of medication.

Interview on [redacted] at 9:00 am, Staff B acknowledged that Resident #2 did not have daily [redacted] sugar information, communication log and [redacted] order. Staff A stated, "The Program had all the information."

Class III

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on record review and interview, the facility failed to provide a contract containing the monthly rate for three of six sampled residents (#1, 2, and 3).

Findings included:

Record review revealed Residents #1, 2, and 3 did not have complete contracts in their file. Residents

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#1, 2, and 3 did not have the monthly payments documented and were not signed.

Interview on at 1:00 pm Staff A stated, "I knew that I have to put the monthly rate for those residents, I postponed to sign them day by day, and I forget to do it; we have eighty residents; it is a lot to do."

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation, record review, and interview, the facility failed to be in compliance with the emergency environmental control requirements.

Findings included:

Observation on at 9:40 am revealed the facility had the generator and monoxide detector, in its original packaging.

Record review revealed that the facility did not have the emergency power plan and/or comprehensive emergency management plan in the facility. In addition, facility did not have written information of each resident/resident representative in writing of the implementation of the plan.

Observation on at 10:00 am revealed Staff B called Staff A regarding the comprehensive emergency management plan (CEMP). However, Staff B could not find the CEMP.

Interview on at 10:00 am Staff B stated, "We have to install the Monoxide detector, the generator is still in the box."

Class III