STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968818	**09/11/2018**
NAME OF PROVIDER OR SUPPLIER **LIVING CARE FACILITY INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **10355 SW 38 TERR** **MIAMI, FL 33165**	

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

0000 - Initial Comments

A complaint (CCR #2018009624) survey was conducted on , 2018 through , 2018. Living Care Facility, Inc. with standard license number 12671, had the following deficiencies identified at the time of survey:

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview, the facility failed to provide proof of the interdisciplinary care plan and other documentation as required by law that showed that one of four sampled residents was under hospice care (Resident #7).

Findings included:

Review of Resident #7's record showed admission on . The last health assessment was dated , showing risk of , no elopement risk. Diagnose listed were: , , Assistance with ambulation, bathing, dressing, eating, , toileting and transferring. There was no referral to hospice on file.

A review of progress notes for Resident 7 showed:
, 2018 - "Resident continues stable and no change at the moment".
, 2018 - "Resident more and decline. Resident is under observation at the moment".

On , 2018 at 11:45 AM, the Owner stated, "Hospice took the records, they usually leave the record but they did not do it this time".

Class III

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

Based on record review and interview, the facility failed to provide care and supervision appropriate to the needs of one of eight sampled residents, (Residents 2) . The resident eloped twice, and was found wandering by the police.

Findings included:

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1)

A review of Resident 2's record showed an admission date of . There was no documentation of an elopement assessment. Health assessment dated showed diagnoses of , , or behavioral status - Memory . No elopement risk. Supervision with ambulation, dressing and toileting. Assistance with bathing, and transferring. Last health assessment dated showed no elopement risk with diagnoses of -Lactamase and level 1.

A review of Resident 2's progress notes showed:

- "Resident doing good at the moment, no change at this time. The resident is very aggressive with the staff and wants to go out to the street. I already told the son and he is aware".

- "Resident continues at the same condition during this month. The resident continues aggressive sometimes with the staff".

- "Resident continues at stable condition at the moment but the resident is screaming and wants to go out".

- "Resident doing good, no change at the moment, no significant change at the moment, no significant change at this time, the resident continues with same, the resident is screaming to the staff and also to me".

- "At 2:36 PM, I received a phone call from the employee telling me that could not find Resident 2 at the facility or around the facility. On my way to the facility, I called the son to let him know but he did not answer, at 2:40 PM he returned my call and I explained what happened and his answer was that the police had found the resident and was at his house; something that left me on doubt due to the resident being totally ; the resident is the type of resident who always wanted to leave and likes a lot to go to the main exit door".

On , 2018 at 11:20 AM, the Owner stated, "The primary doctor would come to the facility, and he said that the meds were Ok and the behavior was due to the condition, the resident had 's".

On , 2018 at 10:00 AM, regarding elopements, the Owner stated, "Well, sometimes they go outside to walk but no, no issues with elopement".

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On , 2018 at 12:17 PM, Resident #2's son stated during a phone interview, "She left the facility and by a miracle, someone on the streets told the police and she remembered my name and the police looked for it and brought her to my house. My wife was there and called me few minutes after the facility had called me to let me know. I live about 10 minutes away from the facility. Now, she did this also about a year or a year and a half ago; the facility called me to let me know that they found her near the facility. So because of the last time and this was the second time, I decided to remove her from that facility. She is now in another facility and doing great."

Class II

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

Based on record review and interview, the facility failed to obtain a resident assessment for risk of elopement as required by law to identify one of eight sampled residents (Resident 2) so staff can be alerted to their needs for support and supervision.

Findings included:

Record review of facility's elopement policies and procedures showed, "#2 - Identify residents that have potential to be elopement risk. #I - Fill out adverse incident report 1-Day and fax to AHCA in Tallahassee within 24 hrs. The facility will also give the resident's family or guardian or responsibility party the information on the 's Association with the intentions to suggest the purchase of an ID bracelet for the resident".

Record review of facility's Wandering and Elopement policy and procedures showed on page 2, "Wandering is defined as in a resident moving about inside or outside the facility without an appreciation for personal safety". On page 3, "Elopement is a situation where a resident wanders away, runs away, escapes or otherwise leaves a care-giving environment unsupervised, unnoticed and prior their discharge".

Record review of Resident 2 showed admission date of . Record review showed no elopement assessment on file. Health assessment dated showed diagnoses of , , or behavioral status - Memory . No elopement risk. Supervision with ambulation, dressing and toileting. Assistance with bathing, and transferring.

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Last health assessment dated . . . . showed no elopement risk and diagnoses of . . . . . level I and ESBL.

Record review of Resident 2's progress notes showed:

. . . . . - "Resident remains the same, no change at the only sometimes the resident is very agitated and screaming to other residents too".

- "Resident doing good at the moment, no change at this time. The resident is very aggressive with the staff and wants to go out to the street. I already told the son and he is aware.

. . . . . - Resident continues at the same condition during this month. The resident continues aggressive sometimes with the staff.

On , 2018 at 11:20 AM, the owner stated, "The primary doctor would come to the facility, and he said that the meds were Ok and the behavior was due to the condition, the resident had . . . . 's".

On , 2018 at 10:00 AM, when Owner was asked "Do you have any problems with any residents eloping from the facility? the Owner stated, "Well, sometimes they go outside to walk but no, no issues with elopement".

On . . . . . , 2018 at 12:17 PM, Resident 2 'son stated on a phone interview, "Resident 2 left the facility and by a miracle, someone on the streets told the police and Resident 2 remembered by name and the police looked for it and brought the resident to my house. My wife was there and called me few minutes after the facility had called me to let me know. I live about 10 minutes away from the facility. Now, the resident did this also about a year or a year and a half ago; the facility called me to let me know that they found the resident near the facility so because of the last time and this was the second time, I decided to remove the resident from that facility. The resident is now in another facility and doing great".

Class III

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

Based on observation, record review and interview, the facility failed to help Resident 6 with self-administration of medications at the time scheduled or within an hour before or after the time scheduled by the medication observation record (MOR). Facility failed to assure that times of

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medications to be given to two of eight sampled residents (Residents 3 and 5) were noted on the MOR as prescribed by doctor.

Findings included:

On , 2018 at 6:59 AM, observed some of the residents in their or seating at the dining table and living .

Record review of the MOR showed medications for Resident 6 scheduled for 8:00 AM. Record review of the MOR showed manual entries of prescribed medications for Residents 3 and 5 with no scheduled times, only AM or PM noted.

On , 2018 at 6:50 AM, Staff D stated, "I already gave the medications to all residents".

On , 2018 at 2:00 PM, the Owner acknowledged that the times of the medications to be given to the residents on the manual MOR were missing.

Class III

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

Based on record review and interview, the facility failed to note changes in the menu before or when the meal was served . (Breakfast).

Findings included:

Record review of breakfast menu scheduled for , 2018 showed juice, dry or cooked cereal, bread with margarine and milk.

On , 2018 at 8:08 AM, observed Resident 3 at the dining table, having dry cereal with milk for breakfast.

On , 2018 at 8:08 AM, Staff D told Resident 3, "Here, drink water, it is good for your kidneys".

Class III

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

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Based on observation and interview the facility failed to maintain a safe living environment free of hazards to all residents and staff.

Findings included:

On , 2018 at 7:10 am, observed outside on the back area of the facility discarded mattresses located by the property fence.

On , 2018 at 7:10 am, Staff D stated, "Those are to be discarded".

Class III

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

Based on record review and interview, the facility failed to add a resident on the facility's admission and discharge log (Resident 8).

Findings included:

Record review of Resident 8 showed an admission date . Last assessment with no date: No , Diagnoses: , , , , and 's. Elopement risk not identified on form. Supervision on ambulation, dressing and transferring. Independent on eating. Assistance with bathing, and toileting. No progress notes on record.

On , 2018 at 1:20 PM, the Owner stated, "Resident 8 was a person who came only for about 7 days but did not like it here and the daughter took the resident from the facility. The resident did not adapt here".

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 submit an initial adverse incident report to the agency within 1 business day after the incident and failed to submit a full adverse incident report to the agency within 15 days of the incident in two different occasions for one of eight sampled residents (Resident 2).

Findings included:

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Record review of Resident 2 showed admission date of . . . . . Record review showed no elopement assessment on file. Last health assessment dated showed diagnoses of , , ... or behavioral status - Memory , ... No elopement risk. Supervision with ambulation, dressing and toileting. Assistance with bathing, and transferring.

Record review of Resident 2's progress notes showed:

- "Resident remains the same, no change at the only sometimes the resident is very agitated and screaming to other residents too".

. . . . . - "Resident doing good at the moment, no change at this time. The resident is very aggressive with the staff and wants to go out to the street. I already told the son and he is aware".

- "Resident continues at the same condition during this month. The resident continues aggressive sometimes with the staff".

. . . . . - "Resident continues at stable condition at the moment but the resident is screaming and wants to go out".

- "At 2:36 PM, I received a phone call from the employee telling me that could not find Resident 2 at the facility or around the facility. On my way to the facility, I called the son to let him know but he did not answer, at 2:40 PM he returned my call and I explained what happened and his answer was that the police had found the resident and was at his house; something that left me on doubt due to the resident being totally ; the resident is the type of resident who always wanted to leave and likes a lot to go to the main exit door".

On , 2018 at 11:20 am, the Owner stated, "No she used to go to the door and tell us that she was leaving but we would watch her outside and she always would come back to the facility". "No, I did not reported it to AHCA. The primary doctor would come to the facility, and he said that the meds were Ok and the behavior was due to the condition, the resident had 's".

On , 2018 at 10:00 AM, when Owner was asked "Do you have any problems with any residents eloping from the facility? the Owner stated, "Well, sometimes they go outside to walk but no, no issues with elopement".

On , , 2018 at 12:17 PM, Resident 2 'son stated on a phone interview, "Resident 2 left the

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facility and by a miracle, someone on the streets told the police and Resident 2 remembered by name and the police looked for it and brought the resident to my house. My wife was there and called me few minutes after the facility had called me to let me know. I live about 10 minutes away from the facility. Now, the resident did this also about a year or a year and a half ago; the facility called me to let me know that they found the resident near the facility so because of the last time and this was the second time, I decided to remove the resident from that facility. The resident is now in another facility and doing great".

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation, record review and interview, the facility failed to store 48 hours of emergency fuel on site. The facility also failed to notify each resident and the resident's legal representative of the existence of the emergency power equipment within 5 business days in writing.

Findings included:

On [redacted], 2018 at 7:15 AM, observed a portable generator stored inside a shed. There was no fuel for the generator.

A review of all resident records showed no written notice of the existence of the emergency power equipment.

On [redacted], 2018 at 2:00 PM, the Administrator acknowledged that the facility needed to store the emergency fule and also to provide the notice to all residents or their legal representative.

Class III

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

Based on record review and interview, the facility failed to update its roster in the background screening clearinghouse for one of six staff members who no longer work at the facility.(Staff B).

Findings included:

Review of the background screening clearinghouse for the facility showed Staff B as the Administrator.

Review of Notification of Change of Administrator form dated showed a request to change Administrators. According to owner, the form was sent to the licensure unit by fax.

On , 2018 at 8:47 AM, the Owner stated, "I have called to see the status of administrator in the system and AHCA tells me that it will be resolved; they have not changed it".

Unclassified