STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942940	**10/10/2018**
NAME OF PROVIDER OR SUPPLIER **SOUTH OAKS ASSISTED LIVING HOME, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **6141 SW 34TH STREET MIRAMAR, FL 33023**	

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

0000 - Initial Comments

An unannounced Extended Congregated Care (ECC) monitoring survey was conducted on through at South Oaks Assisted Living Home, LLC, License # 5855. The facility had deficiencies at the time of the visit.

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

Based on observation, interview and record review, the facility failed to coordinate with the third party provider to facilitate the receipt of care and services to meet the resident ' s needs. This was evidenced by the failure to develop, implement and document the facility policy for the coordination and oversight of third party services for monitoring/care to 1 of 1 sampled residents (Resident # 1), who had history of and physical decline.

The findings include:

Review of Resident #1 ' s medical record indicated that she was admitted to the assisted living facility (ALF) on with medical diagnosis of muscle incontinence, dependent and . The current health assessment dated on indicated Resident #1 is alert and oriented to person and place but with . She required total assistance with activities of daily living (ADL) care, including toileting, bathing, self- care, dressing and total assistance with self- administration of medication. Further review of the assessment indicated her skin condition included a sacral .

In an interview with the facility caregiver on at 10:30AM, she stated that Resident #1 recently returned from the nursing home on , after receiving treatment for a sacral . She stated that Resident #1 had muscle and required total assistance for her ADLs, including toileting, bathing, dressing and medication management. She stated that due to , the resident remained in bed most of the day and would get out of bed with staff assistance to a wheelchair occasionally. She stated that Resident #1 was ordered an air mattress, but it was not inflating properly. The caregiver stated that Resident #1 is visited by the Home Health Agency nurse three times a week for care of the sacral . The caregiver stated that she was unaware of the condition of the or any instructions for overall care. She stated that she does not document any care that she provides to the resident.

In an observation of Resident #1 on at 10:45 AM, the resident was observed lying in a

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hospital bed with an air mattress attached to the bed. The resident was on her back, asleep. In an additional observation on at approximately 11:30AM, the resident was observed to be unable to turn herself on her side and required total assistance from caregiver. In an additional observation on at 1 PM, the resident was observed in bed, lying on her back with her head slightly elevated on a pillow.

Review of the Home Health Agency nursing notes starting on , indicated that Resident #1 was initially assessed to be alert, oriented to person and place but forgetful. The notes indicated that the resident was of bowel and and totally dependent for ADL care including toileting, bathing, and dressing. Additionally, Resident #1 was assessed to have overall and was chair fast, but able to transfer with assistance. The resident was receiving daily medication management for her dependent .

Review of the Home Health nurses note dated on indicated the start of care for a sacral , , . The note indicated the measurements as 1cm x1cm x 0.2cm with 80% tissue, and minimal drainage was noted.
Review of the Home Health nurses note dated on indicated that the sacral had worsened and the measurements were noted as 3.5cm x 2.5cm x 1.0 cm with 70% tissue.

Review of the Home Health nurses note dated on indicated the sacral was unstageable, measuring 2.5cm x 2.0 cm x 1.0 cm with 100% . The note indicated that the nurse recommendation to reposition the resident every 2 hours and off -loading the resident's heels on pillows. New care orders were ordered to treat the change in condition.Review of the Home Health nurses note dated on indicated the sacral remained unstageable measuring, 2.5cm x 2.0cm x1.0cm with 100% .

In an interview with the Home Health Agency care , , Advanced Registered Nurse Practitioner (ARNP) on at 8:30AM, she reviewed her notes and stated that Resident #1 had previously been treated for an unstageable sacral , around . She stated that her coworker had recommended that Resident #1 be transferred to the hospital for treatment of the . The ARNP stated that recently she had been called by the Home Health Agency to restart care visits for Resident #1. She stated that on , she assessed the resident's sacral to be a , with little . She stated that she visited Resident #1 on , and found that the sacral had gotten worse, with more . She stated that this change prompted her to take a culture/sensitivity of the to determine possible and that the test results were not available. She stated that she was very concerned that the air mattress on Resident #1's bed was not functioning properly and could be directly contributing to the worsening condition. She stated that

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she had informed the Administrator of her concerns with the air mattress on a previous visit, but it had not been replaced. She stated that in her opinion Resident #1 was not being positioned properly as required to promote healing.

Review of Resident #1's nursing home medical record indicated that on , she was admitted from the hospital to receive rehabilitation and treatment of a . Review of the initial care nursing note dated on indicated Resident #1 had an unstageable sacral with and tissue. Further review indicated Resident #1 was transferred to the hospital on for a with , and returning to the nursing home on . Resident #1 was assessed on readmission to have a sacral , . Resident #1 was followed by a care and care was performed daily as ordered by the facility staff.

Review of the Care Physician progress note dated on indicated that Resident #1's chronic sacral was stable and slowly improving. The note indicated that the chronic showed improvement with measurements of 2cm x 2cm x1cm, 50% pink , 5% with light . Review of the Care Physician progress note dated on indicated the measurement as 2cm x 2.4 cm x 0.8 cm with exposure, and moderate drainage with 0% and 100% . The Physician note indicated that the is stable, improving on the current regimen and becoming more superficial. The note further indicated the overall struggle to maintain the periwound due to , and bowel incontinence.

Review of nursing home interdisciplinary progress notes indicated Resident #1 was seen by the house physician on .Review of a physician order dated indicated the resident "Needs HHA, RN, and treatment for sacral ". Review of an additional physician order date indicated "Disregard above orders. Patient discharge is on hold due to sacral . Wound physician to evaluate in AM".

Review of a nursing home progress note for Resident #1, dated on indicated that the resident left the facility against medical advice (AMA). Review of the facility" Release of Responsibility for Discharge Against Medical Advice " form dated on indicated that the form was signed by the ALF Administrator on at 10:45 AM. Review of Resident #1's "Designation of Health Care Surrogate " form dated on , indicated the ALF Administrator as her health care surrogate.

During an interview with another state agency representative on at 1 PM, he expressed his concerns for Resident #1's well-being and worsening condition, after she was removed from the nursing home and returned to live at the ALF. He stated that the ALF Administrator had voiced his disapproval of the nursing home's actions concerning financial/ insurance reimbursements and then

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removed Resident #1 from the facility.

Review of Resident #1's facility record indicated no written progress notes that document the residents overall condition, any facility implementation/coordination of recommended care by the 3rd party provider or resident's response to the care treatments being provided.

During an interview with the Administrator on at approximately 1PM, he stated that he had no specific facility policy concerning 3rd party providers and communication between the facility and providers. When questioned about facility documentation of Resident #1's condition and any treatments, he stated that he had not been documenting the progress or any care provided by his staff. He stated that the Home Health Agency was providing services for Resident #1 and her sacral was a . He stated that Resident #1 had been in the nursing home and recently was readmitted to the ALF, he did not mention that he had removed the resident AMA.

Class II

0052 - Medication - Assistance with Self-Admin - 429.256(3-4); 58A-5.0185 (3)

Based on observation, interview and record review, the facility failed to provide assistance with self-administration of medication according to the requirements identified in 429.256, F.S. This was evidenced by Staff #A who has not completed required training to assist with self administration of medications was providing medications to 8 of 10 sampled residents (Residents # 1,#2,#3,#7,#8 and #10).

The findings include:

A review of the facility census report revealed that there were 8 residents in the facility on .

Review of the 2018 Medication Observation Record (MOR) on at 11:00 AM indicated that Staff #A had documented that she had provided prescribed medications to Residents #1,#2, #3, #7, #8 and #10 and on the following days, 10/1,10/2,10/6,10/7 and .

Review of Staff #A's personnel record indicated she had been hired on . Further review of the file indicated that there was no documentation of Staff A continuing education training on providing assistance with self-administration of medications and safe medication practices prior to performing the task.

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During an interview with the Administrator on at approximately 1 PM, he stated that he was aware that Staff#A needed to have the required annual medication training, but he had he forgotten to coordinate the training. He stated that he would be scheduling the training for Staff #A .

Class III

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on observation, interview and record review, the facility administrator failed to provide adequate oversight and supervision of the facility staff to ensure appropriate care and services was provided to all residents. This was evidenced by the failure to develop, implement and document a facility policy for the coordination and oversight of third party services for care, for 1 of 1 sampled residents, (Resident #1) and failure to coordinate the completion of required staff training for assistance with self administration of medications for 1 of 2 sampled staff(Staff #A) and Extended Congregated Care (ECC) training for 2 of 2 sampled staff (Staff #A and #B).

The findings include:

1) Review of Resident #1 ' s medical record indicated that she was admitted to the assisted living facility (ALF) on with medical diagnosis of muscle , incontinence, dependent and . The resident is alert and oriented to person and place but with . The current health assessment dated on indicated Resident #1 required total assistance with activities of daily living (ADL) care, including toileting, bathing, self- care, dressing and assistance with self- administration of medication. Further review of the assessment indicated her skin condition included a sacral , .

During an interview with the facility caregiver on at 10:30 AM, she stated that Resident #1 recently returned from the nursing home on , after receiving treatment for a sacral , . She stated that Resident #1 had muscle and required total assistance for her ADLs, including toileting, bathing, dressing and medication management. She stated that due to , the resident remained in bed most of the day and would get out of bed with staff assistance to a wheelchair occasionally. She stated that Resident #1 was ordered an air mattress, but it was not inflating properly. The caregiver stated that Resident #1 is visited by the Home Health Agency nurse three times a week for care of the sacral , . The caregiver stated that she was unaware of the condition of the or any instructions for overall care. She stated that she does not document any care that she

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provides to the resident.

During an observation of Resident #1 on at 10:45 AM. the resident was observed lying in a hospital bed with an air mattress attached to the bed. The resident was on her back, asleep. In an additional observation on at approximately 11:30 AM, the resident was observed to be unable to turn herself on her side and required total assistance from caregiver. In an additional observation on at 1 PM, the resident was observed in bed, lying on her back with her head slightly elevated on a pillow.

Review of Resident #1's nursing home Care Physician progress note dated on indicated the chronic measurement as 2 cm x 2.4 cm x 0.8 cm with exposure, and moderate drainage with 0% and 100% . The Physician note indicated that the is stable, improving on the current regimen and becoming more superficial. The note further indicated the overall struggle to maintain the periwound due to , and bowel incontinence.

Review of the Home Health Agency nursing notes starting on , indicated that Resident #1 was initially assessed to be of bowel and and totally dependent for ADL care including toileting, bathing, and dressing. Additionally, Resident #1 was assessed to have overall and was chair fast, but able to transfer with assistance.
Review of the Home Health nurses note dated on indicated the start of care for a sacral , , . The note indicated the measurements as 1cm x1cm x 0.2cm with 80% tissue, and minimal drainage was noted.Review of the Home Health nurses note dated on indicated that the sacral had worsened and the measurements were noted as 3.5cm x 2.5cm x 1.0 cm with 70% tissue.
Review of the Home Health nurses note dated on indicated the sacral was unstageable, measuring 2.5cm x 2.0 cm x 1.0 cm with 100% . The note indicated that the nurse recommendation to reposition the resident every 2 hours and off -loading the resident's heels on pillows. New care orders were ordered to treat the change in condition.

During an interview with the Home Health Agency care , Advanced Registered Nurse Practitioner (ARNP) on at 8:30 AM, she stated that recently she had been called by the Home Health Agency to restart care visits for Resident #1. She stated that on , she assessed the resident's sacral to be a , with little . She stated that she visited Resident #1 on , and found that the sacral had gotten worse, with more . She stated that this change prompted her to take a culture/sensitivity of the to determine possible and that the test results were not available. She stated that she was very concerned that the air mattress on Resident #1's bed was not functioning properly and could be directly contributing to the

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worsening condition. She stated that she had informed the Administrator of her concerns with the air mattress on a previous visit, but it had not been replaced. She stated that in her opinion Resident #1 was not being positioned properly as required to promote healing.

Review of Resident #1's facility record indicated no written progress notes that document the residents overall condition, any facility implementation/coordination of recommended care by the 3rd party provider or resident's response to the care treatments being provided.

During an interview with the Administrator on at approximately 1 PM, he stated that he had no specific facility policy concerning 3rd party providers and communication between the facility and providers. When questioned about facility documentation of Resident #1's condition and any treatments, he stated that he had not been documenting the progress or any care provided by his staff. He stated that the Home Health Agency was providing services for Resident #1 and her sacral was a . He stated that Resident #1 had been in the nursing home and recently was readmitted to the ALF, he did not mention that he had removed the resident AMA.

2) Review of the posted employee schedule for 2018 indicated that Staff #A was listed as direct care staff, scheduled to work 24 hour shifts from 7 AM to 7 AM., 3 days a week. Further review of the schedule indicated on from 7 AM to at 7 AM, Staff # A was working alone from 2 PM,no other employees were documented as scheduled to work. Further review indicated that on and 10/7 /2018 Staff #A worked 24 hour shifts and she was alone after 7 PM. No other employees were documented as scheduled to work after 7 PM on both days. Review of the employee schedule from 2018 indicated that Staff # A had worked numerous 24 hour shifts and at times there were no other staff on duty.

Review of , 2018 and 2018 Medication Observation Record (MOR) for 6 of 8 current residents, (Resident #1-3,#7,#8 and #10) indicated that Staff #A had signed the record that she had assisted the residents with their prescribed medications.

Review of Staff #A's personnel record indicated she had been hired on . Further review indicated that there was no documentation of Staff#A's attending continuing education training on providing assistance with self-administration of medications and safe medication practices prior to performing the task.

During an interview with the Administrator on at approximately 1 PM, he stated that he was aware that Staff#A needed to have the required annual medication training, but he had he forgotten to

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coordinate the training. He stated that he would be scheduling the training for Staff #A .

3) Review of the Agency web site, Florida HealthFinder.gov,on indicated the facility holds a current Standard and Extended Congregated Care license.

Review of the Administrator's personnel file indicated he had completed 4 hours of updated ECC training on . Review of the training certificate indicated topics reviewed including resident care, rules and laws pertaining to an ECC license and Medication Administration and Progress notes .

Review of the facility's policy for ECC staff training indicated that direct care staff employed by the facility will complete the required 2 hour ECC training.

Review of personnel records revealed no documentation of Extended Congregated Care (ECC) training completion by Staff A (hire date) and Staff # B (hire date).

During an interview conducted with the Administrator on at approximately 1:00 PM, he stated, " I have not provided the required ECC training to the employees, it is my fault".

Class II

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

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Based on observation,interview and record review,the facility placed residents at risk by failing to ensure care staff have completed the necessary inservice training for assistance with self administration of medications and safe medication practices. This was evidenced by the failure of staff to complete required continuing education training for 1 of 2 sampled employees, (Staff # A) who works alone on a 24 hour shift at the facility.

The findings include:

Review of the posted employee schedule for 2018 indicated that Staff #A was listed as direct care staff, scheduled to work 24 hour shifts from 7 AM to 7 AM., 3 days a week. Further review of the schedule indicated on from 7 AM to at 7 AM, Staff # A was working alone from 2 PM,no other employees were documented as scheduled to work. Further review indicated that on

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and 10/7 /2018 Staff #A worked 24 hour shifts and she was alone after 7 PM. No other employees were documented as scheduled to work after 7 PM on both days. Review of the employee schedule from , 2018 indicated that Staff # A had worked numerous 24 hour shifts and at times there were no other staff on duty.

Review of , 2018 and 2018 Medication Observation Record (MOR) for 6 of 8 current residents, (Resident #1-3,#7,#8 and #10) indicated that Staff #A had signed the record that she had assisted the residents with their prescribed medications.

Review of Staff #A's personnel record indicated she had been hired on . Further review indicated that there was no documentation of Staff A attending continuing education training on providing assistance with self-administration of medications and safe medication practices prior to performing the task.

During an interview with the Administrator on at approximately 1 PM, he stated that he was aware that Staff A needed to have the required annual medication training , but he had he forgotten to coordinate the training. He stated that he would be scheduling the training for Staff #A .

Class III

E203 - ECC - Staffing Requirements - 58A-5.030(3) FAC

Based on observation,interview and record review, the facility failed to follow the requirements for Extended Congregated Care (ECC) licensure. This was evidenced by the failure to maintain the required staff or contracted services of a nurse to be available to provide nursing services and failure to ensure and document that care staff received ECC training required in rule 58A-5.0191, F.A.C.

The findings include:

Review of the agency web site, Florida HealthFinder.gov,on , indicated the facility holds a current Standard and Extended Congregated Care license. Review of the facility's policy for ECC staff training indicated that direct care staff employed by the facility will complete the required 2 hour ECC training.

Review of personnel records for Staff A (hire date) and B (hire date) revealed no documentation of completed Extended Congregated Care (ECC) training.

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Review of the facility personnel file for the contracted ECC nurse indicated an agreement dated between the facility and contracted registered nurse who will supervise all residents admitted to the ECC program . Further review of the file indicated a copy of the contracted nurse's license with an expiration date, , as well as as an expired ( ) training card dated . No documentation of ECC training was available for review.

During an interview conducted with the Administrator on at 1:00 PM, he stated, " I have not provided the required ECC training to the employees , it is my fault". When questioned about the expired documentation in the contracted ECC nurse's personnel file, he stated that the nurse was no longer the ECC nurse and he had contracted with another nurse. He stated that he did not have updated documentation for surveyor review.

Class III

E210 - ECC - Training - 58A-5.0191(8) FAC

Based on record review and interview, the facility failed to ensure that 2 out of 3 employees (Staff A and B) providing care in an Extended Congregated Care (ECC) licensed facility complete the required 2 hours of inservice training within six months of employment.

The findings include:

Review of the agency web site, Florida HealthFinder.gov,on indicated the facility holds a current Standard and Extended Congregated Care license. Review of the facility's policy for ECC staff training indicated that direct care staff employed by the facility will complete the required 2 hour ECC training.

Review of personnel records revealed no documentation that Extended Congregated Care (ECC) training was completed by Staff A (hire date) and Staff # B (hire date).

During an interview conducted with the Administrator on at approximately 1:00 PM, he stated, " I have not provided the required ECC training to the employees, it is my fault".

Class III