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

Based on observation and record review, the facility failed to maintain an up-to-date employee roster in the Background Screening Clearinghouse Database.

Findings included:

On at 5:30 AM Staff D and Staff E were observed in the facility providing services to residents. A review of the Background Screening Clearinghouse Database showed that Staff D and Staff E had an eligible level II background screening result.

A review of the facility's roster in the Background Screening Clearinghouse Database on revealed that Staff D hired on and Staff E hired on were not listed.

Unclassified

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

Based on observation, record review, and interview the facility, licensed to serve six, failed to obtain a licensure capacity increase prior to providing personal care and meals to a census of seven sampled residents (Residents #1-7).

Findings included:

During a facility's tour on at 5:35 AM, four resident and one as "Employee" were observed with a total of seven beds. Six residents were observed in the facility and there was one at the hospital during the visit.

A review of the facility's records on revealed that Resident #3, #6, and #8 were not listed on the facility's admission and discharge log.

A review of the residents' record on revealed that Resident #3 was admitted on , Resident #6 was admitted on , and Resident #8 marked as daycare participant was admitted on .

During an interview on at 8:30 AM, Resident #8 "I live with my daughter but I slept here yesterday because she could not come to pick me up."

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0000 - Initial Comments

Biennial

A Standard Biennial Survey in conjunction with a Complaint Investigation (CCR 2018013456) were conducted from to . Amor De Dios (License #10069) had deficiencies at the time of the surveys:

0004 - Licensure - Requirements - 58A-5.016 FAC

Based on record review and interview, the facility failed to have an updated copy of the annual fire safety and sanitation inspections.

Findings included:

A review of the facility's fire approval document revealed that there was a final notice issued on by the Miami Dade Fire Rescue Department for non fire and life safety permit. The facility did not have a fire and life safety permit. Also, the sanitation inspection document dated was expired.

During an interview on 11:02 AM, the Administrator stated that they had the sanitation document, but he was unable to provide it for a review.

Class III

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on observation and record review, the facility failed to ensure that two out of nine sample residents (Resident #1 and #3) met the minimum admission minimum criteria. The facility admitted two bedridden residents (#1 and #3). Resident #1 in the facility 14 hours after admitted to hospice. Resident #3 was removed from the facility by the Department of Children and Families, and was hospitalized.

Findings included:

1) A review of Resident #1's file on showed that there was a health assessment dated . Based on the health assessment, resident was diagnosed with Parkinson's ,

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, , , , , Chronic Insufficiency, , , . She was receiving total care with ambulation, bathing, dressing, and transferring. She needed assistance with eating and toileting. The resident was admitted non-ambulatory and needed total care on .

Review of the resident's hospice record revealed that she was enrolled in hospice care until on and 14 hours later on she . At the initial hospice assessment, Resident #1 was dependent with bathing, transferring, toileting, dressing, and eating. She was diagnosed of , , ( ), and without behavioral disturbance. Her medical history was (cannulated hip screw (CHS), bed ridden, and Severe . Resident was on 80 mg tablet, , 37.5 - 25 mg capsule, 10 - 100 10 mg 100 mg tablet, 40 mg tablet, , 25 mg tablet, 40 mg tablet DR, , 50 mg tablet, and 0.25 mg tablet. No notes were written about the resident .

2)
On at 5:31 AM observed Resident #3 lying in bed. Throughout the day the resident was observed in her bed unable to perform activities of daily living without assistance. The resident was , and could not be interviewed.

A review of Resident #3 on revealed that the resident was admitted on . The resident had no documentation of a health assessment. Resident #3 was on , 15 mg tablet and , 10 mg tablet.

On at 7:15 AM, observed unlicensed Staff E brought a pill crusher with one tablet inside of it to the dining area and said "this medication is for Resident #3." Then, unlicensed Staff E crushed the medication and put it in a small cup. Staff E walked to Resident #3's , mixed the medication with food and fed Resident #3.

In an interview on at 9:03 AM, Staff D stated that Resident #3 refused to get out of the bed.

In an interview on at 2:31 PM, Resident #3's family member stated "Resident #3 cannot walk. She went to the hospital and when she came back shortly before she got to this home, she stopped walking."

On On at around 1:00 pm, Resident #3 was transported to the hospital by emergency ambulance.

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

Based on record review, and interview, the facility failed to have resident's health assessment completed within 60 days prior to admission into the facility or 30 days after been admitted in the facility for two out of eight (Resident #1 and #3) sample residents.

Finding included:

Resident's record showed that for Resident #1 admitted on , the physician completed the health assessment on and for Resident #3 admitted on , there was no documentation of the health assessment.

Interview conducted on at 1:00 PM, Administrator said that he did not know anything regarding the facility. Staff B and Staff F operated the facility but they were unable to participate in the survey. Staff B was out of country and Staff F was in his other facility.

Class III

0027 - Resident Care - Arrangement for Health Care - 58A-5.0182(3) FAC

Based on record review and interview facility failed to provide access to adequate and appropriate health care consistent with established and recognized standards within the community for two out of nine sampled residents (Resident #1 and #3). Resident #1 received no health care during a three month stay at the facility, and . Resident #3, who was bed bound and nonverbal, was not under a doctor's care and was removed from the facility and hospitalized.

Findings included:

1) A review of the admission/discharge log showed that Resident # 1 A review of Resident #1's file showed that the resident was admitted on and was discharged to the funeral home on .

A review of the resident record showed a health assessment dated 11/ , four months before the resident was admitted to the facility. Resident #1 was diagnosed with Parkinson's , , , Chronic Insufficiency, and , . She needed total care with ambulation, bathing, dressing, and transferring. She needed assistance with eating and toileting.

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Further review of the record showed no documentation that Resident #1 received any medical care between and . There was no documentation of the resident's enrollment in hospice. was not provided, and emergency medical services were not called. No notes were written about the resident's .

A review of the hospice record showed that Resident #1 was enrolled in hospice care on . The initial hospice assessment showed Resident #1 needed total care for bathing, transferring, toileting, dressing, and eating. The resident was diagnosed with , ( ), and without behavioral disturbance. Her medical history was (cannulated hip screw (CHS)), bed ridden, and Severe . The resident was prescribed 80 mg tablet, 37.5 - 25 mg capsule, 10 - 100 10 mg 100 mg tablet, 40 mg tablet, , 25 mg tablet, 40 mg tablet DR, , 50 mg tablet, and 0.25 mg tablet. The documentation showed that the resident had no other identified primary care provider on enrollment; the hospice provider was selected as the primary care physician. Further review showed the resident at the facility 14 hours later, around midnight on .

Further review of the resident record showed no documentation of a properly executed ( ). The resident's Power of Attorney (POA) was signed by a niece and a nephew, giving themselves authority to make decisions for the resident. A review of the showed that the nephew who signed the POA also signed the order. The order was not signed by the resident's primary care physician (the hospice physician) until after the resident's .

Interviewed on at at 11:33 AM, Staff D stated "I never performed . I called 911 on different occasions but not related to . They never instructed me to perform ."

Interviewed on at 2:10 pm, Resident #1's niece confirmed that Resident #1 did not see a physician while she lived at the facility. She stated that this was because she changed her aunt's insurance and her aunt before it was changed.

2) On at 5:31 AM observed Resident #3 on her hospital bed. Throughout the day the resident was observed in bed unable to perform activities of daily living without assistance. The resident was unable to get out of bed.

A review of Resident #3's record revealed that the resident was admitted on . The resident had no documentation of a health assessment or any other indication that she was under a doctor's care.

On at 7:15 AM, observed unlicensed Staff E brought a pill crusher with one tablet inside of it

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to the dining area and said "this medication is for Resident #3." Then, unlicensed Staff E crushed the medication and put it in a small cup. Staff E walked to Resident #3's , mixed the medication with food and fed Resident #3.

A review of the medication observation record (MOR) showed that Resident #3 was being given , 15 mg tablet and , 10 mg tablet. There was no documentation of a physician's order for the medication. There was no documentation of a physician's order for the medication to be crushed.

Interviewed on at 9:03 AM, Staff D stated that Resident #3 refused to get out of bed.

Interviewed on at 2:31 PM Resident #3's daughter stated "my mother cannot walk. She went to the hospital and when she came back shortly before she got to this home, she stopped walking."

On at around 2:51 pm, the resident was removed by the Department of Children and Families and hospitalized for assessment.

Class II

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

Based on observation, record review, and interview, the facility failed to ensure that three out of eight (Residents #3, #4 and #5) sampled residents were treated with dignity and respect, free of . The residents were restrained by bed rails and could not get out of bed without staff's assistance or permission. The facility also failed to to obtain a written physician order for use of bed rails for Resident #3 #4 and #5. The facility failed to have a resident consent for the use of full bed rails for one out of eight (Resident #5) sampled residents.

Findings included:

Facility tour conducted on at 5:35 AM showed Resident #3 had half bed rails attached to her bed and Resident #4 and #5 had full bed rails attached to their beds. The residents could not remove the bed rails or get out of bed without staff assistance.

Resident record review showed that there was no physician order for the use of half bed in Resident's #3 record. Resident's #4 record had a full bed rails order dated and Resident's #5 had a full bed rails order dated . There was no resident consent for the use of full bed rails for Resident #5.

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Interviewed on at 1:00 PM, the Administrator said that he did not know anything regarding the facility, and that Staff B and Staff F operated the facility but they were unable to participate in the survey because Staff B was out of country and Staff F was in another facility.

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 #4 and #5).

Findings included:

A review of Resident #4's file on revealed that the residents' last three hospice plans of care were dated , , and ; Resident #5's last three hospice plan of care was dated , , and .

During an interview on at 6:30 AM, the home health nurse stated "I am the hospice nurse. I am here for Residents #4 and #5."

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, record review, and interview, the facility failed to ensure that licensed staff provided administration of medications to two out of five residents (#3 and #6).

Findings included:

On at 7:15 AM, observed Staff E brought a pill crusher with one tablet inside of it to the dining area and said "this medication is for Resident #3." Then, Staff E crushed the medication and put it in a small cup. Staff E walked to Resident #3's , mixed the medication with food and fed Resident #3.

On between 7:15 AM and 7:52 AM, observed that Staff E did not clean the pill crusher at any time.

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On at 7:52 AM, observed that Staff E took one tablet out of each pack of 50 MCG, ER 30 MG, 100 mg, 150 mg, and Centrum Silver that belong to Resident #6. Staff E put the tablets inside the pill crusher, crushed the medications, took out the medications from the pill crusher with a spoon, mixed it with water, and put the spoon inside resident's mouth.

A review of Resident #3's file revealed that the resident was admitted on . Resident #3 did not have a health assessment available for a review.

A review of Resident #6's file revealed that on the health assessment dated the physician ordered assistance with medications and crushed medications mixed with apple sauce.

Class III

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

Based on observation, record review, and interview, the facility failed to ensure that all medications were kept in a locked cabinet, locked cart, or other locked storage receptacle, , or area at all times. Unlocked medications were found for two out of nine sampled residents (Resident #2 and #3). The facility also failed to properly dispose of medications for one out of nine sampled residents (Resident #1).

Findings included:

During the facility's tour on at 5:35 AM, there were three brown paper bags observed on top of the desk located in the common containing packages medications for the month of , 2018 that belongs to Resident #2, Resident #4, and Resident #5. Also, Resident #1's medications were observed in the medications' cabinet. A jar of was also observed on the dresser in #.

A review of Resident #1's file on revealed that the resident on .

During an interview on at 6:10 AM, Staff D stated "the medications came last night." Staff D added "we are waiting on Resident #1's family member to pick the medications up."

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

Based on observation, record review, and interview, the facility failed to obtain a written medication order for crushed medication from a health care provider for one out of five sampled residents (Resident #3).

Findings included:

On at 7:15 AM, observed Staff E brought a pill crusher with one tablet inside of it to the dining area and said "this medication is for Resident #3." Then, Staff E crushed the medication and put it in a small cup. Staff D walked to Resident #3's , mixed the medication with food and fed Resident #3.

A review of Resident #3's file on revealed that the resident was admitted on . Resident #3's file did not have a health assessment available for a review and did not have a physician's order for crushed medication.

Class III

0076 - ( ) - 58A-5.0186 FAC

Based on record review and interview, the facility failed to provide , , ( ) to one of eight sampled residents, who did not have a properly executed ( ), and who became unresponsive and (Resident #1). The facility also failed to have documentation for seven out of eight sampled residents' choices regarding and failed to maintain documentation indicating whether or not a Department of Health (DH Form 1896) had been executed for these residents (Residents #1, #2, #3, #5, #6, #7, and #8).

Findings included:

1) During a facility tour on at 5:35 AM, observed Resident #1's medications in the medication cabinet. A review of the admission and discharge log showed that Resident #1 had and was picked up by a funeral home.

A review of Resident #1's file revealed that the resident on . There was no documentation of a .

Review of the resident's hospice record revealed that she was enrolled in hospice care until on

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three months after admission to the facility and 14 hours later on she . At the initial hospice assessment, Resident #1 was dependent with bathing, transferring, toileting, dressing, and eating. She was diagnosed of , , ( ), and without behavioral disturbance. Her medical history and diagnoses were cannulated hip screw (CHS), bed ridden, and Severe . Resident #1 was on - to treat failure and to lower the risk of after a - 80 milligrams (mg) tablet, , - treat high , - 37.5 - 25 mg capsule, - to treat Parkinson -10 - 100 10 mg 100 mg tablet, - to treat high - 40 mg tablet, , - to treat , and , - 25 mg tablet, - to treat erosive , , - 40 mg tablet DR, , treat chest pain and high , - 50 mg tablet, and - to treat , and , - 0.25 mg tablet. There were no notes written about circumstances surroundings the resident .

Further review of Resident #1's hospice records on revealed that there was a signed by the resident family member on . The did not state whether or not that the family member was the resident's appointed Power of Attorney (POA). Further review of the resident record showed no documentation of a properly executed ( ). The resident's Power of Attorney (POA) dated was signed by a niece and a nephew, giving themselves authority to make decisions for the resident. A review of the dated showed that the nephew who signed the POA also signed the order. The order was not signed by the resident's primary care physician (the hospice physician) until after the resident's .

In an interview on at around 3:15 PM, the hospice nurse team manager stated that she did not know whether the was properly executed because it was the admitting nurse who would have reviewed the document. She further stated that she did not know the Hospice's policies or procedures on when the physician should sign a order.

During an interview on at 11:33 AM, Staff D and Staff E stated that if a resident was found unresponsive, they would call 911 and follow the instructions given by the 911 operator. Staff D and Staff E added that they would only perform , , ( ) after calling 911 and would follow the instructions given by the 911 operator to perform .

2) A review of Resident #2, #3, #6, #7, and #8 on showed no documentation of a .

A review of Resident #5's record on showed no documentation of a . Review of the facility's hospice record for the resident showed a progress note dated and stating that had been signed meaning that the resident had a , and the hospice Plan of Care dated also stated that the resident was "full code" (wish to be). This was confusing as "full

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code" means to intercede if a patient's stops beating or if the patient stops breathing. It is the opposite code of meaning "."

In an interview on at around 11:00 AM, the hospice nurse stated that these were errors, and that Resident #5's daughter/POA did not want the resident to have a .

On at 11:30 AM observed the acting administrator called the hospice nurse to ask if Resident #5 had a or no.

In an interview on 11:36 AM, the acting administrator and the caregivers stated that they did not know whether the resident had a or not.

A review of the facility's 's policies and procedures on stated "The facility will carry out the legal and medical wishes of a that has been completely filled out by resident/legal representing guardian and a physician. The facility will only honor a state of Florida that is on yellow paper and has been executed.

Class II

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

Based on record review and interview, the facility failed to ensure that it was under the supervision of a qualified qualified administrator who was responsible for the operation ad maintenance of the facility, management of all staff, and provision of appropriate care. The acting administrator was not core certified. A resident after not receiving when no properly executed was in place. A resident and broke her hip due to inadequate supervision. The facility was operating beyond its licensed capacity of six, caring for seven residents. Unlicensed staff was administering medication.

Findings included:

Cross reference citations A0027, A0076, Z828.

1) Record review revealed that the current Administrator was hired on .

Interview conducted on at 1:00 PM, the Administrator said that he did not know anything regarding the facility, and that Staff B and Staff F operated the facility but they were unable to participate

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in the survey because Staff B was out of country and Staff F was in another facility.

A review of the certification database (CORE certification) on showed no records that the Administrator passed the test.

During an interview on at 1:25 PM, the Administrator stated "I did not take the test. The Owner took it, but he did not pass."

2) A review of Resident #1's file on showed that there was a health assessment dated . Based on the health assessment, resident was diagnosed with Parkinson's , , , Chronic Insufficiency, . She was receiving total care with ambulation, bathing, dressing, and transferring. She needed assistance with eating and toileting. The resident was admitted non-ambulatory and needed total care on . Review of the resident's hospice record revealed that she was enrolled in hospice care until on and 14 hours later on she . At the initial hospice assessment, Resident #1 was dependent with bathing, transferring, toileting, dressing, and eating.

Based on the hospice records, Resident #1 became unresponsive on and the facility did not perform . Resident #1 did not have a valid ( ).

In an interview on 11:36 AM, the acting administrator and the caregivers stated that they did not know whether the resident had a or not. None of the staff including the administrator and the acting administrator did not have an understanding about .

3) The facility failed to ensure that two out of nine sample residents (Resident #1 and #3) met the minimum admission minimum criteria. The facility admitted two bedridden residents (#1 and #3). Resident #1 in the facility 14 hours after admitted to hospice.

On at 5:31 AM observed resident #3 in bed. Throughout the day the resident was observed in her bed unable to perform activities of daily living without assistance.

A review of Resident #3 on revealed that the resident was admitted on . The resident had no documentation of a health assessment. Resident #3 was observed bed bound and unable to perform activities of daily living without assistance. She was on , 15 mg tablet and , 10 mg tablet. Unlicensed Staff D fed the Resident crushed medication in her food. There was no documentation of a crush medication order. The resident was removed by the Department of Children and Families (DCF) during the survey on and was sent to the hospital for assessment and

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placement at a higher level of care.

4) The facility provided services to residents outside the current license capacity of six. During the facility's tour on at 5:35 AM, four resident's one as "Employee" were observed with a total of seven beds. Six residents were observed in the facility and there was one at the hospital during the visit.

A review of the facility's records on revealed that Resident #3, #6, and #8 were not listed on the facility's admission and discharge log.

A review of the residents' record on revealed that Resident #3 was admitted on , Resident #6 was admitted on , and Resident #8 marked as daycare participant was admitted on .

Class II

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

Based on record review, and interview, the facility's personnel records did not include a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable for one out of five (Staff G) sampled staff.

Findings included:

Personnel record review showed no documentation of a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable for Staff G (hire date).

Interviewed on at AM, the Administrator said that he did not know anything regarding the facility because Staff B and Staff F operated the facility but they were unable to participate in the survey. Staff B was out of country and Staff F was in another facility.

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 an additional 2 hours of continuing education training on providing assistance with self-administered medications and safe medication

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practices in an ALF for one out of five sampled staff (Staff I). The facility failed to ensure that one out of six sampled staff received a minimum of 2 hours of continuing education training on providing assistance with self-administered medications (Staff G).

Findings include:

Personnel record review showed no documentation that Staff I had received an additional 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an ALF. Staff I was hired on and completed four hours of medication training on .

Personnel record review showed Staff G received two hours of medication training on . There was no documentation of two hours of continuing education training annually.

On at 1:00 PM, the Administrator said that he did not know anything regarding the facility because Staff B and Staff F operated the facility but they were unable to participate in the survey and Staff B was out of country and Staff F was in another facility.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review and interview, the facility failed to ensure that four out of five sampled staff received adequate ( ) training (Staff A, D, E, and F).

Findings included:

A review of the personnel files revealed that Staff A, hired on , had 1 hour of training certificate issued on ; Staff D, hired on , 1 hour of training certificate issued on ; Staff G, hired on , 1 hour of training certificate issued on ; and Staff F, hired on , 1 hour of training certificate issued on .

During an interview on at 8:14 AM, Staff D stated "I received the training."

During an other interview on at 11:09 AM, Staff D, Staff E, and the acting administrator were unable to explain what were.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965702	**10/18/2018**
NAME OF PROVIDER OR SUPPLIER **AMOR DE DIOS**	STREET ADDRESS, CITY, STATE, ZIP CODE **718 NW 132 PLACE** **MIAMI, FL 33182**	

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

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 free of hazards, and failed to ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances were maintained in good working order.

Findings included:

On at 5:37 AM during a facility tour, observed: # had a missing closet door, # 's glass sliding door had no blinds or covering; the 's door between # and #3 had peeling paint; the laundry's wall had a large cracked that looked like a punched hole; the laundry's door had a hole; the backyard had broken furniture, commode, wheelchair, and an used mattress. (photos)

During an interview on at 7:49 AM, Staff D acknowledged the findings.

Class III

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

Based on record review, and interview, the facility failed to provide documentation of a satisfactory annual fire inspection and sanitation inspection.

Findings included:

Observation on at 6:00 AM showed a fire inspection final notice dated stating that the facility needed to obtain a permit, and a sanitation inspection dated posted on the bulletin board.

Interview conducted on at 1:00 PM, Administrator stated that the facility had a current sanitation inspection but he did not provide it during the survey.

Class III

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

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965702	**10/18/2018**
NAME OF PROVIDER OR SUPPLIER **AMOR DE DIOS**	STREET ADDRESS, CITY, STATE, ZIP CODE **718 NW 132 PLACE** **MIAMI, FL 33182**	

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

Based on record review, and interview, the facility failed to ensure the staff records had documentation of the required Level 2 background screening results for two out of five (Staff D and I) sampled staff.

Findings included:

Review of Staff D's and I's records showed they did not contain documentation of the level 2 background screening.

A review of the Agency's background screening database showed she had an eligibility status for Staff D dated . . . . . and Staff I dated . . . . . .

Interviewed on . . . . . at 1:00 PM, the Administrator said that he did not know anything regarding the facility because Staff B and Staff F operated the facility but they were unable to participate in the survey and Staff B was out of country and Staff F was in anther facility.

Class III

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

Based on observation, record review, and interview the facility failed to have documentation of the appointment of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney for two out of eight sampled residents (Resident #2 and #3) . The facility failed to have a complete health assessment for one out of eight sampled residents (Resident #4). The facility failed to have the weight record initiated on admission for one out facility residents eight (Resident #3). The facility failed to have weights documented every six months for three out of eight sampled residents (Resident #2, #3, and #4).

Findings Include:

Observation on at 6:30 AM showed hospice registered nurse administered medications to to Resident #4.

Record review for Resident's #2 showed that the contract done on . . . . . was signed by her daughter and Resident's #3 contract done on was signed by her daughter. There was no documentation of the appointment of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney in their records. Residents #4 health assessment done on . . . . did not specify whether the residents required any assistance with the administration of medications. Resident's #3 admitted on

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

did not have documentation of her weight at the time of admission. Resident #2, #3 and #4 records did not have documentation of their weight every six months. Resident #2, #3 and #4 receive assistance with the activities of the daily living.

Interview conducted on at 1:00 PM, Administrator said that he did not know anything regarding the facility, and that Staff B and Staff F operated the facility but they were unable to participate in the survey because Staff B was out of country and Staff F was in another facility.

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 file a one day incident report for one out of nine sampled residents who and had broken bones (Resident #2).

Findings included:

During an interview on at 5:41 AM Staff D stated that Resident #2 and broke her hip two days ago, and that the ambulance transported the resident to the hospital.

Review of Resident #2's file on revealed that there was no documentation on the .

A review of the hospital record on revealed that Resident #2 was admitted at a local hospital on //18 at 1333 for "hip pain and unable to walk after falling from bed." Resident #2 was later on diagnosed with "pubic ."

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation and interview, the facility failed to have monoxide detectors installed. The facility also failed to notify the residents and their legal representative in writing of the implementation of the plan.

Findings included:

During the facility tour on at 5:37 AM, no monoxide detectors were observed installed in the facility.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

A review of the facility's Emergency Power Plan policies and procedures book on revealed that there was no documentation of the residents' notification of the implementation of the plan available for a review.

During an interview on at 10:33 AM the Administrator stated "no, we don't have Monoxide Detectors."

Class III

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(9) FAC

Based on record review, and interview, the facility failed to ensure that three out of five sampled staff received the initial limited mental health (LMH) training within 6 months of employment (Staff A, F and G).

Findings included:

A review of Staff A, F and G employee's file showed the facility did not have documentation that the staff received the Limited Mental Health (LMH) initial training. Staff A was hired on /18, Staff F was hired on and Staff G was hired on .

On at 1:00 PM, the Administrator said that he did not know anything regarding the facility. He further stated that Staff B and Staff F operated the facility but they were unable to participate in the survey because Staff B was out of the country and Staff F was in another facility.

Class III