STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966974	**11/30/2018**
NAME OF PROVIDER OR SUPPLIER **MARY'S CARE CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **30796 SW 189 AVENUE** **HOMESTEAD, FL 33030**	

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

0000 - Initial Comments

A Complaint (CCR# 2018014850) Survey was conducted on , and concluded on , . Mary's Care Center with Limited Mental Health component had the following deficiencies identified at the time of the survey:

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

Based on record review and interview, the Assisted Living Facility failed to provide care and services to meet the needs of the residents for one out of seven residents (#3) who was hospitalized and sustained multiple injuries. Resident #3, who had to one side of his body, sustained multiple injuries after falling off his bicycle when the facility allowed him to leave the premises without any supervision. The resident was hospitalized and/or treated at the emergency room eight times in nine months.

Findings included:

On at 10:51 AM, the Administrator revealed Resident #3 went to the hospital on and returned on or 5th. She sent him to the hospital later because he was not doing well. At 10:54 AM, the Administrator added Resident #3 returned on the 5th and went to the hospital. The first time Resident #3 outside of the facility, he was alone. He went out in the morning to the clinic that was close to Krome Avenue. He used his bicycle. The hospital called the facility and informed that the resident was in the hospital. He was transferred from one hospital to another hospital. When he returned from the hospital, Resident #1 complained of and did not want to eat so the facility sent him to the hospital.

Review of Resident #3's hospital record showed an admission date of . The physical assessment showed that the resident had right side , (on one side of the body). The discharged diagnoses and plan were hematoma without loss of , closed injury due to bicycle accident, acute , , ETOH ( ) , and ( ). The admission records revealed Resident #3 had a history of two prior injuries, right upper extremity , damage, use who presents to emergency room with a . The hospital note stated, apparently, the resident grabbed the bike from the ALF, left and but he did not recall the incident. He was found by fire rescue and transferred to the hospital where Resident #3 was found with hematomas. He had a in the of his . At the time of the admission the resident was , , poor judgement, and aggressive. Test completed to the (Computed without Contrast) completed on at 3:40 PM showed impressions of multiple acute bifrontal and ,

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and hematomas.

On at 12:55 PM, Staff B stated Resident #3 did not listen and revealed the resident had a drinking problem. The owner did not want the bike at the facility because he had one arm that did not work, and did not want him to leave like that but he liked the street. The day of the accident on , Resident #3 left the facility around 8 am on the bicycle. The hospital called around 2:00 pm or 3:00 pm and informed the facility that Resident #3 was in the hospital.

On at 2:12 PM, the Administrator reported Resident #3 abused , his primary physician was aware of it. He went out and sometimes returned drunk. When the Administrator talked to him, he answered that he was not in jail. The Administrator believed she told him he would be discharged if he did not behave but she did not discharge him. The Administrator reported that she did not allow bicycle in the facility but he got it anyway. She did not want the bicycles in the facility because she knew that it could cause problems and it did. The Administrator said she had concerns about Resident #3 bicycle usage but there was nothing she could because he continuously repeated that he was not in jail. She further stated they "had to be careful with him because he could be violent," although she denied that he had ever been physically aggressive to the staff or other residents in the facility.

On at 10:04 AM, Resident #3's primary physician's nurse revealed Resident #3 was an . She stated that they provided education to him, but did not communicate with the facility because the resident did not give them permission. She further stated that their offices knew that Resident #3 had problems with from his bike, 6 or 7 times during the last year. In one of the cases he suffered a but she was not sure if it was or . At 10:14 AM, she revealed that the resident had at least 5 visits to the ER (Emergency Room) and at least 3 admissions to various hospitals, including the one connected to the clinic where the primary physician worked. ER visits were on , , , and . Admissions to hospital were on , and . She revealed Resident #3 was admitted to a hospital approximately 3 weeks ago and discharged to the ALF, which had to send him to another hospital.

On at 11:59 AM, the Administrator confirmed Resident #3 had more hospitalizations during the past year, which she thought were related to problems with the bicycle.

Review of Resident #3's hospital record showed that on , the resident had surgery, , irrigation and debridement of right , and removal of loose body right . Resident #3 presented in the hospital on , after 3 days following a bicyclist hit by a car incident where he injured his right . He first had , but increased with warmth, , and inability to bear . Additional hospital record review showed an admission on due to right , and

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had right , on . He was admitted to hospital on due to , related to right . The principal diagnosis was right . Further review of the medical record showed: History of present illness showed that the resident was well known to the orthopedic service with past medical history of , , EtOH , cord injury due to motor vehicle accident presents to the hospital after being struck by vehicle while riding bicycle with concern for right . Resident #3 was discharged on with 6 weeks of , , 2 mg twice a day and , , 500 mg daily, via ( ) line. According to the Centers for control, "a central , also known as a central line, is a tube that doctors place in a large in the , , or arm to give fluids, or medications or to do medical tests quickly." A review of the Florida statutes and Assisted Living Facility regulations showed that residents in need of a line do not meet the admission criteria for an assisted living facility.

On , Resident #3 returned to the hospital and reported that he woke up with severe , . He reported that was unable to ambulate or bear . He stated that went for a long walk the day prior to admission. Resident #3 was admitted to hospital on due to , related to right , . The secondary diagnoses were right tricompartmental , due to , (,)/ , cord injury due to MVA (motor vehicle accident), dyslipidemia, intermittent explosive , and EtOH . The hospital recommended home , and the resident confirmed that he had a walker and wheelchair at home. He was discharged to the ALF on with his ( ) and was to follow up with an clinic on . Discharge medications were , 1000 mg every 8 hours as needed for , , 500 mg every 8 hours as needed for , and continue all other home medications including : , 500 mg daily and , 2 mg every 12 hours, both with end of treatment on . There was no documentation of how the resident's medications were being administered when he returned to the ALF.

Review of Resident #3's record showed, he was admitted to the facility on . Resident #3's last health assessment (AHCA form 1823) completed on had a medical history and diagnoses of , , , of , low , deformity of right arm, and , . Resident #3 needed assistance with activities of daily living and required precautions.

The last progress notes completed by the facility for Resident #3 was dated . There was no documentation regarding any hospitalizations, , nursing services, bicycle accidents, or behavior concerns.

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Class I

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

Based on record review and interview, the Assisted Living Facility failed to arrange medical care for one out of seven sampled residents (Resident #2) sampled who had a , in the , an on the left heel, and to forehead, right , and left lateral , .

Findings included:

On at 9:42 AM, the Administrator revealed that Resident #2 at the hospital about 8 days ago. The administrator further stated that the last time she saw Resident #2 was on , when she visited the resident at the hospital. She had a (,) while in hospital and was admitted to hospice. At 11:46 AM, the Administrator revealed that Resident #2 from the bed on and had a to the forehead. She further stated that Staff C was on duty, and that the happened in the afternoon after dinner.

Interview with Staff C on at 9:32 AM revealed she placed Resident #2 in bed on . Then she went to take another resident to the bathroom and after that Staff C found that Resident #1 was on the floor in her bedroom. She called 911 and Resident #2 was transferred to the hospital.

Review of Resident #2's hospital record from revealed Resident #2 arrived to the hospital by a private, non-emergency ambulance on at 6:48 PM with a to the saturated in dry . Hospital records revealed the resident was found on the floor in the morning with a to her forehead. She had a , in the , and on the left heel and to forehead, right , and left lateral , when admitted to the hospital. Hospitalization diagnoses included accidental , acute injury, , , , of left , of forehead and of right upper arm. Review of a multidisciplinary progress note on at 8:36 PM documented that the resident's four extremities were covered with (discoloration of the skin) in various stages of healing. Progress note entered by social services on at 2:03 PM showed that the resident's son confirmed that the resident lived at the ALF for the past months. She had a wheelchair at ALF. The resident was mostly bedbound and non-verbal prior to admission. The nursing assessment dated revealed the resident was non-verbal bedbound and . Progress notes of doctor on showed that the resident had a , , and left heel . The hospital record indicated Resident #2 required complete assistance for the activities of daily living. Hospital discharge date was on and hospital discharge orders stated that the resident was to be seen by her physician within three (3) days of discharge.

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The facility did not have any documentation that Resident #2 on , Resident #2 was seen by a physician after discharging from the hospital on , or any documentation that care was provided.

On at 11:25 am, the office manager of resident's primary physician was contacted. The doctor's office was unaware of Resident #2's . Their records identified Resident #2's last visit was , . They had not seen her since then. She had been receiving home health services for care earlier in the year, but those services ended on .

Review of Resident #2's hospital record showed that the resident was admitted to the hospital on and discharged on . The chief complaint was , on left ankle . The ambulance service sheet showed that she was sent to the hospital due to a , on the left and to lower extremities. Skin assessment completed at the time of admission on showed that she had on , left , left hematoma. She had heel . The triage assessment completed on during hospitalization showed that Resident #2 was bedbound.

Review of Resident #2's home health agency file revealed the care started on . The home health agency discontinued the care when the resident went to the hospital on because the were larger and not healing.

Review of Resident #2's hospital record showed that she went to the hospital on . The resident was diagnosed with , , non-pressure of limited to breakdown of skin, , on the , with base noted on the left heel. The resident was admitted to CCU (Critical Care Unit) on at 5:26 PM due to serious condition until ; her skin was dry, had (grade) and heel , and was and weak. On , she underwent sharp debridement of . On , the resident had a placement due to and calorie intake, and she was transferred in the hospital to hospice care ALF unit.

Review of Resident #2's record revealed the resident was admitted on . Resident #2's health assessment completed on documented the the resident required , skin, , and precautions. The medical history and diagnoses were , , , , , ( ), , , 's , , ( ), , / Aphasia. Services requirements showed that she needed , / , for strengthening. The facility did not have any progress notes for

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Resident #2 or any evidence that the resident received .

Class I

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

Based on record review and interview, the Assisted Living Facility failed to provide ( ) to one out of seven residents who did not have a ( ) in place (Resident #1). Resident #1 was found in a chair his pupils fixed and dilated, with lividity and established, after Staff B did not call emergency services after the resident's change in condition.

Findings included:

On at 9:45 AM, the Administrator revealed that Resident #1 was and . Staff called 911 and declared him in the facility.

Review of the fire rescue report showed that emergency call was received on around 10:23 AM. Rescue arrived to the facility on at 10:37 AM. The resident found sitting on chair in / , . Staff informed that the last time the resident was seen alive was at 9 AM. The resident was unresponsive and with absent of breath sounds; he had lividity, , pupils fixed and dilated. He was to touch and pale. Disposition was at scene after of 3 lead showed rhythms, the showed that the did not have activity.

Record review found Resident #1 did not have a . Review of Resident #1's record showed that the admission date was on . The health assessment (AHCA form 1823) completed on had a medical history and diagnoses were: late effect of ( ), Dependent, , , , , ( ). He was identified as a risk and needed assistance with all activities of daily living.

The last written progress notes were dated , stating that the resident had appropriate behavior, participated in activities, had a good appetite, was sleeping and did not have problems with his medications. He was ok and went to a podiatry . There was no other documentation at the facility.

On at 12:34 PM, Staff B stated Resident #1 was sick, really sick and did not take care of himself. She made rounds during the night around 10 PM and 2 AM. In the morning, around 7 AM, the

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resident was asleep and she did not wake him up. When the staff went to check on the resident around 9 AM, he was pale and , was faint; he had very little breathing, and was tense. She called the private, non-emergency ambulance. She did not check if he was responsive. One hour and twenty three minutes later, then she decided to call 911 because the ambulance was taking too long. She states she told them that the resident did not answer, but said that the 911 operator did not give her any instructions.

On at 1:15 PM, the Administrator revealed that all the residents in the facility wanted to be . She stated that probably the staff though that the resident ate something or something happened. She further stated that staff was too nervous. The administrator though that probably the 911 operator told the staff to leave the resident alone. They did not know the cause of .

On at 12:43 PM, Further interview with Staff B revealed the facility call rescue for Resident #1 because he had something that made him looked like . The day before, she arrived between 6 PM and 7 PM, and he asked her for some food. She gave him a milk with proteins, and then he went to bed after he took his medications. She woke up two times during the night and checked on the residents, he was sleepy. Next morning, around 7 AM, he took his medications and she helped him to transfer to chair but he was down. She called the owner and informed her. The owner told her to call the ambulance. The ambulance took too long, around 40 to 50 minutes. She called the ambulance company again and they told her to call 911. She called the second time because the resident stopped talking to her. She checked the , and he was not breathing well but she did not check , . She did not perform to Resident #1.

Class I

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

Based on observation and interview, the Assisted Living Facility failed to keep centrally stored medications locked at all times.

Findings included:

On at 9:02 AM, observed the medication cabinet unlocked. The medications were individually divided in labeled bins. Staff was not present, Residents #4 and #6 were siting in the living room.

On at 12:30 PM, Staff C revealed that she knew that medications needed to be locked. She was providing morning care and forgot to close the cabinet.

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Class III

0076 - ( ) - 58A-5.0186 FAC

Based on record review and interview, the Assisted Living Facility failed to have policies and procedures in place so that staff had guidance on ( ) for one out of three sampled staff (Staff B). Staff B, who was on duty, failed to provide First Aid and ( ) to Resident #1 who did not have a .

Findings included:

Cross Reference to A 0030. Based on record review and interview, the Assisted Living Facility failed to provide ( ) to one out of seven residents who did not have a ( ) in place (Resident #1). Resident #1 was found in a chair his pupils fixed and dilated, with lividity and established, after Staff B did not call emergency services after the resident's change in condition.

Review of Staff B's personnel record showed that hire date was on training completed on and on . On at 12:34 PM, Staff B revealed that she did not recall what was a .

On at 1:13 PM the Administrator revealed that Staff B probably was nervous and that the reason she did not remember what was.

On at 1:47 PM, the administrator revealed that she did not know if she has policies and procedures. She will check and get to surveyor. The staff does not know anything about paper.

Class I

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

Based on observation and interview, the Assisted Living Facility failed to provide a safe living environment.

Findings included:

On at 9:08 AM, Resident #6 revealed that one of the grab bars in the bathroom near the toilet was broken and she was scare to .

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On at 9:10 AM, observed the bathroom between # # . One of the two grab bars near the toilet was loose from the wall. It was secured to the floor but had missing screws that held to the wall. Behind the toilet, plaster and paint was peeling.

On at 9:11 AM, observed the bathroom inside the room had brownish greenish stain on the tiles in the shower.

On at 1:11 PM, the Administrator revealed that the bathrooms needed to be clean. The problem with the toilet grab bar will be fixed, it happened the previous Friday.

Class III

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

Based on interview and record review, the Assisted Living Facility failed to keep an updated admission and discharge log.

Finding included:

On at 9:07 AM, Staff C revealed Resident #2 at the hospital about 8 days ago.

Review of facility's admission and discharge log showed Resident #2's did not have a discharge dated documented.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(&) FS; 58A-5.0241 FAC

Based on record review and interview, the Assisted Living Facility failed to provide a report to the agency within 1 business day and within 15 days after the occurrence of an adverse incident for three out of seven sampled residents (#1, #2, and #3). Resident #1 and the staff did not provide ( ). Resident #2 from bed causing to the forehead and hospitalization plus two others hospitalizations without giving consent. Resident #3 from his bike, causing .

Findings included:

The facility did not submit an adverse incident report to the Agency regarding Resident #1's in the facility.

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The facility did not submit an adverse incident report regarding Resident #2's that cause acute injury, of left , of forehead and right upper arm.

The facility did not submit an adverse incident report regarding Resident #3's multiple on his bicycle when staff failed to provide adequate supervision.

On at 1:27 PM, the Administrator revealed the she did not complete reports because it needs to be completed when the facility failed to do something and cause problems to the residents in the facility. Resident #1 just . The for Resident #2 was nothing big. When the resident returned from the hospital, the administrator was not able to see the , and regarding the , Resident #2 was receiving care. Resident #3 outside the facility and the facility had a policy that they were not responsible for what happens to residents outside the facility. He wanted to ride the bicycle and she could not say no.

Class III