STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966238	**12/05/2018**
NAME OF PROVIDER OR SUPPLIER **JUAN PABLO II ALF, CORP.**	STREET ADDRESS, CITY, STATE, ZIP CODE **15680 SW 139 AVENUE** **MIAMI, FL 33177**	

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

0000 - Initial Comments

A complaint (CCR#2018013533) survey was conducted on , through , . Juan Pablo II ALF, Corp., with a standard license, had the following deficiencies identified at the time of survey:

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on observation and interview, the facility failed to provide a decent living environment, free from , for two of seven sampled residents (Residents #2 and 3). Resident #2 was restrained by the use of a chair which she could not move, and Resident #3 was restrained by a sofa in front of her bed, which she could not remove.

Findings included:

1) Resident 2 - On , from 7:15 AM to 3:15 PM during the time of the survey, observed Resident 2 seating all day in the living room and not able to transfer, stand, put both flat on the floor and walk by herself without the assistance of two staff.

On , at 12:40 PM - Observed that Resident 2 could not get up by herself. Both the administrator and staff B helped her to get up and sat her at the dining table.

On , at 1:47 PM, observed Resident 2 indicating that she was ready to go to the recliner after her lunch and the Administrator could not assist the resident by herself. Observed the administrator call someone by phone, then push a chair close to the recliner to prevent Resident #2 from getting up. The Administrator left the resident there, then went to the kitchen.

On , at 1:52 PM - Observed that Staff B came to help the Administrator to put Resident 2 on the recliner; the administrator told her, "I could not do it myself."

On , at 2:00 PM, observed Staff B leaving left the facility.

On , at 7:15 PM - Observed Resident 2 sitting on the same seat in the living room. The Administrator, who was now the only staff working at the facility, contacted a family member of the resident to assist her in lifting the resident from the seat to transfer her to the bathroom because she was working by herself and did not have qualified staff who could go and work at the facility. The resident, who had not been moved for several hours, had a adult brief that emitted a foul odor.

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2) On [redacted], at 7:15 PM, observed a sofa in front of Resident 3's bed. The Administrator stated at 7:30 PM, "I did it because she wants to get up every 10 minutes to go to the bathroom but once she goes to sleep, I remove it and then she calls me if she wants to go to the bathroom."

On [redacted] at around 5:5;15 pm, observed Residents #2 and 3, after being assessed by the Department of Children and families, being transported to the hospital for further assessment and placement.

Class III

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

Based on observation and record review, the facility failed to keep prescribed medication for one of seven sampled residents (Resident 4) in a secure place that was out of sight of other residents.

Findings included:

On [redacted], at 7:30 AM, observed in an unlocked room , a container full of prescribed and labeled medications for Resident 4. In addition, observed Medication Observation Record (MOR) documents from [redacted] and [redacted].

Review of all prescribed medications found, showed medications for the morning, afternoon and for before bed time with a current date of [redacted]. The MOR documents found showed prescribed medications for several months including years 2017 and 2018.

On [redacted], at 10:15 AM, the Administrator, after acknowledging that Resident 4 was a current resident and not a adult day care participant, put all the prescribed and labeled medications inside the medication cabinet that was kept locked in the kitchen area.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observation, record review, and interview the facility failed to have qualified staff to provide resident supervision and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs of two of seven sampled residents (Residents 1 and 2). The residents, who needed the assistance of two or more staff to perform activities of daily living , had only

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the assistance of one qualified staff. The facility also failed to maintain a written work schedule that reflected its 24-hour staffing pattern for a given time period.

Findings included:

1) On , at 7:30 AM, observed Staff B and C working in the facility with a census of seven residents. A review of the facility's licensure data showed that it was licensed for six residents.

On , at 7:15 AM, Staff C stated that she did not have any ID with her. Staff B stated that she started today at 5:30 AM and will work until 7 PM and that Staff C slept at the facility every day. At 7:35 AM, Staff B stated, "I told you the wrong thing. Staff C started at 5:30 AM; her nephew brought her. I am the one who sleeps here. I am sorry, I got nervous."

A review of the staffing pattern posted on the bulletin board for to 10th, 2018 showed staff who either were not working any longer at the facility or were not in the facility's roster.

On , at 7:55 AM, the Administrator stated, "Staff D left last Friday and Staff E had to leave because the daughter had a medical emergency and she needed to take care of her. I know that the schedule is not updated and neither the roster in the system; I do not have a consultant and keep leaving things for later and for tomorrow. The woman you saw this morning, I do not know her name, I only know her nickname and I do not have any ID (identification) from her."

On , between 7:15 AM and 11:40 AM, observed Staff C assisting residents with activities of daily living and between 7:15 AM and 2:00 PM, observed Staff B assisting residents with activities of daily living and also preparing food.

Review of personnel records and the background screening clearinghouse database showed no eligible level 2 background screening for Staff B or C.

2) On , from 7:15 AM to 3:15 PM, observed Resident 1 sitting in the living room all day and not able to transfer, stand, or walk. The resident, whose were , was unable to eat without staff assistance. At around 7:48 AM, observed Staff C feeding oatmeal to Resident 1. Staff B stated, "Resident 1 does not have strength on his ." At 9:50 AM, observed the Administrator give a cup of juice to Resident 1, opening the resident's to put the cup in it. At 12:51 PM, observed that Resident 1 could not get up by himself. The Administrator, assisted by Staff B who did not have an eligible level II background screening or documentation of the required training, put the resident in a wheel chair and brought him to the dining table. The Administrator fed the resident.

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Review of Resident 1's record showed last health assessment dated listed diagnoses of , prostatic hyperplasia, and , . No special precautions were noted. According to the assessment, the resident needed assistance with ambulation, , eating, grooming, toileting and transferring, and total assistance with bathing. The only progress note in the file was dated .

3) On , from 7:15 AM to 3:15 PM, observed Resident 2 seated all day in the living room. At 7:48 AM, observed Staff C feeding oatmeal to Resident 2. At 9:50 AM, observed Staff B giving a cup of juice to Resident 2 and the resident could not hold it. The staff had to bring the cup to the resident's . The resident and not able to transfer, stand, put both flat on the floor and walk by herself without the assistance of two staff. At 7:48 AM, observed Staff B feeding Resident 2. Staff B stated, "Resident 2 does not have strength on her ." At 12:40 PM, observed that Resident 2 could not get up by herself. Both, the Administrator and Staff B helped her to get up and sat her at the dining table. At 1:47 PM , Resident 2 needed to be transferred to a recliner after lunch and the Administrator could assist the resident by herself. The Administrator was observed calling someone by phone, then pushing a chair close to the recliner and leaving the resident restrained there. At 7:15 PM, observed Resident 2 still sitting on the same seat. The resident had an adult brief which had not been changed all day, and which had a foul odor. The Administrator, who was then the only person working at the facility, called a family member of the resident who lived nearby to assist her in taking the resident to the bathroom.

Review of Resident 2's record showed a health assessment with diagnoses of , , , , , , and non- . No special precautions were identified. The resident needed supervision with ambulation, eating and grooming; assistance with bathing, , toileting and transferring. There were no notes about significant changes in the resident's condition. The file contained a ½ bed rail prescription dated .

On at around 5:5;15 pm, observed Residents #2 and 3, after being assessed by the Department of Children and families, being transported to the hospital for further assessment and placement.

Review of Resident 1's hospital record dated showed an admitting diagnosis of , and that the resident needed total assistance to move.

Review of Resident 2's hospital record dated showed admitting diagnoses of , with full assistance in mobility.

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Class II

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

Based on record review and interview, the facility failed to submit the required adverse incident report within one business day after an incident and a complete report within 15 days of the incident for one of seven sampled residents (Resident 3).

Findings included:

Review of Resident 3's record showed progress notes dated:

: Resident 3 around 5:30 am going to the bathroom, her got weak and to the front; sent to the hospital.
: Resident 3 broke the and is getting surgery,Thursday the 18th.
: The surgery was a success.
: Resident 3 sent to rehab, she feels a lot better.
: I went to see the resident and is receiving ; the family is happy with the process.
: Today the resident went to the hospital and they took the bandage and sent her for exercises for the arm. She has an with the doctor .
No more notes on record.

Review of the incident report database and facility records showed no documentation of an incident report having been filed.

On at 9:30 AM, the Administrator stated, "No, I do not think it was reported."

Class III

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

Based on observations, record review and interview, the facility failed to update the employee roster in the background screening clearinghouse database within 10 days of employment for two of five sampled staff (Staff B and C).

Finding included:

On , , between 7:15 AM and 11:40 AM, observed Staff C assisting residents with activities of daily living and between 7:15 AM and 2:00 PM. Observed Staff B assisting residents with activities of daily living and also preparing food for residents.

Review of the facility's roster in the background screening clearinghouse database showed that Staff B and C were not listed.

Review of personnel records showed none for Staff B and C which included an eligible level 2 background screening.

On , , at 7:15 AM, Staff C stated that she did not have any ID with her. Staff B stated that she started at 5:30 AM that day and would work until 7 PM and that Staff C slept at the facility every day. At 7:35 AM, Staff B stated, "I told you the wrong thing. Staff C started at 5:30 AM; her nephew brought her. I am the one who sleeps here. I am sorry, I got nervous."

On , at 8:30 AM, in an interview at the facility Resident 6's son stated, "I know Staff B maybe for a month; Staff C maybe 2 or 3 weeks. They both are here all the time. The owner comes 3 or 4 times per week and Staff D used to work here."

Unclassified

Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on observation, record review, and interview, the facility failed to have a level 2 background screening performed for two of five sampled staff (Staff B and C).

Findings included:

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On , between 7:15 AM and 11:40 AM, observed Staff C assisting residents with activities of daily living and between 7:15 AM and 2:00 PM, observed Staff B assisting residents with activities of daily living and also preparing food.

Review of personnel records and the background screening clearinghouse database showed no eligible level 2 background screening for Staff B or C.

Unclassified

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

Based on observation, interview, and record review, the facility exceeded it's licensed capacity. Seven residents were living onsite.

Findings included:

Review of the Florida Health Finder licensure data showed that the facility was licensed for six residents.

On , at 7:15 AM, observed Residents #1, 2,3,4,5,6 and 7 onsite. When asked for resident records, Staff B brought records for six residents, excluding the seventh record, for Resident # 4. Observed Resident 4 sitting in the living room with the other six residents. At 7:30 AM, observed a room with two beds, armoire and a closet full of men clothes, the staff mentioned that it was Resident 4's room. On a side table, observed a container full of prescribed and labeled medications for Resident 4. In addition, observed Medication Observation Record (MOR) documents from and . The room was next to the bathroom that connected to Resident 1's room.

On , at 7:50 AM, Resident 4 stated, "I have been here for about 2 years. I do not remember that well."

Review of all prescribed medications found for Resident #4 showed medications for the morning, afternoon and for before bed time with a current date of . The MOR documents found showed prescribed medications for several months including years 2017 and 2018.

On , at 10:15 AM, the Administrator, after acknowledging that Resident 4 was a current resident and not an adult day care participant, put all the prescribed and labeled medications inside the locked medication cabinet in the kitchen area.

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Review of Resident 4's record, once provided, showed an admission date of . The resident was diagnosed with non- , high , and , , , . The resident had limited vision and hearing, was at risk of , and was not an identified elopement risk. The resident was independent with eating and needed supervision with ambulation, bathing, , toileting and transferring.

Unclassified