STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964394	11/29/2018
NAME OF PROVIDER OR SUPPLIER **SALMO 23 ELDER CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **277 EAST 4 STREET** **HIALEAH, FL 33010**	

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

0000 - Initial Comments

A Standard Biennial was conducted on , . Salmo 23 Elder Care with Limited Nursing Services and Limited Mental Health components had deficiencies identified at the time of the survey:

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

Based on observation, record review and interview the facility failed to ensure that one out of 13 sampled residents met the continuing residency criteria (# 1). The resident had a placed at the hospital and was sent to the facility which did not have required extended congregate care component which allowed for the provision of the needed services to the resident.

Findings included:

Review of Resident #1's record revealed he was discharged from the hospital with a (,) tube to the assisted living facility . Further review showed that the facility had a standard license and a specialty license for the limited mental health component. Review of the Assisted Living Facility regulations revealed residents admitted to standard , limited nursing services, or limited mental health licensed facilities may not require assistance with . Facility notes revealed the nurse by the facility to provide limited nursing services was administering medications and food via the to Resident #1.

Resident #1's last health assessment was dated on at the facility. There was no documentation of an updated health for Resident #1 after the resident had a or hospice admission, and no indication of whether the resident's needs could be met. There was no documentation regarding Resident #1's diet, , or the required assistance needed with medications.

On at 9:30 AM Staff B stated the nurse comes to feed Resident # 1 the limited nursing services nurse comes to feed him and give the medications. He stated the resident came to the facility after he had the , because his family refused to get him out of the facility and the hospital said that since he had been living at the facility for a long time he could come under hospice services.

On at 9:45 AM the nurse (case manager) from hospice stated Resident #1 was admitted to hospice but the home health nurse was the one providing the medications. There was no documentation that hospice staff was in the facility 24 hours per day to address any emergent needs that might arise related to the .

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On at 9:50 AM Resident #1 stated, "the girl from hospice changed the this morning. They do every day."

On at 3:10 PM the limited nursing services nurse arrived to the facility and stated that he is the one administering the medications and the food (, one can twice a day) to Resident # 1.

Class III

0081 - Training - Staff In-Service - 58A-5.0191( ) FAC

Based on record review and interview the facility failed to have the 2 hours pre-orientation training prior to interacting with residents for two out of four (Staff F and G) sampled staff members and to ensure one out of seven (F) had the require in-services.

Findings included:

Review of Staff F (hired) and Staff G (hired) files found there was no documentation that they had received the two hours pre-service orientation covering resident rights, the facility license type, services offered by the facility prior to interacting with residents.

Review of Staff F's (hired 1023/18) file revealed she did not have the 1 hour in resident rights and recognizing reporting and neglect training.

Interview on at 3:25 PM Staff B acknowledged the staff did not have the two hour orientation or training as required.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC 429.52 (6), FS

Based on record review and interview the facility failed to ensure that one out of seven (F) staff members that assisted residents with self-administration of medications received the initial training.

Findings included:

Record review revealed Staff F (hired) received 2 hours of training on assisting with self-administration of medication on . Staff F did not have documentation proving she received

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the initial 6 hours on assisting with self-administration of medication.

On at 3:15 PM Staff B acknowledged Staff F did not have the required training on medications.

Class III

0085 - Training - Nutrition & Food Service - 58A-5.0191(7) FAC

Based on record review and interview the facility failed to have the 2 hours continuing education in topics pertinent to nutrition and food service for two out of seven (Staff E and F) sampled staff.

Findings included:

Review found Staff E and F's documentation of the minimum of 2 hours continuing education in topics pertinent to nutrition and food service was a copy which was filled out and had no seal from a licensed dietician.

On at 3:30 PM with Staff B acknowledge the seal was not on training and it was a copy.

Class III

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

Based on record review and interview the facility failed to ensure to have documentation of the , , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney for one out of 13 sampled residents (#1).

Findings included:

Record review of Resident #1 revealed that his contract had been signed by his sister on .

On at 12:30 PM Staff B stated, "She is the one signing for him but she has not brought the legal documents."

Class III

E200 - ECC - Licensing - 58A-5.030(1) FAC

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Based on observation, record review and interview the facility failed to obtain a license prior to accepting residents needing extended congregate care services.

Findings included:

Review of Resident #1's record revealed he was discharged from the hospital with a ( ) tube to the assisted living facility . Further review showed that the facility had a standard license and a specialty license for the limited mental health component. Review of the Assisted Living Facility regulations revealed residents admitted to standard, limited nursing services, or limited mental health licensed facilities may not require assistance with .

On at 9:30 AM Staff B stated the nurse comes to feed Resident # 1 the limited nursing services nurse comes to feed him and give the medications. He stated the resident came to the facility after he had the because his family refused to get him out of the facility and the hospital said that since he had been living at the facility for a long time he could come under hospice services.

On at 9:45 AM the nurse (case manager) from hospice stated Resident #1 was admitted to hospice but the home health nurse was the one providing the medications. There was no documentation that hospice staff was in the facility 24 hours per day to address any emergent needs that might arise related to the .

Class III

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Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on record review and interview the facility failed to have the updated background screening results for one out of seven (Staff A) sampled staff members.

Finding included:

Review of Staff A file found a background screening dated . The background screening database search on found the last screening for Staff A was dated . The facility did not have an update background screening in Staff A's file.

On at 4:00 PM Staff B acknowledged findings after review of Staff A's file.

Class III

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c); 59A-35.090(2)(d)-(3)

Based on record review and interview the facility failed to have the background screening attestation form for one out of seven (Staff F) sampled staff members.

Finding included:

Review of Staff F's file revealed she did not have the background screening attestation of compliance form completed and signed.

On at 4:00 PM Staff B stated, "I thought it was in Staff F's file."

Class III

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

Based on observation, record review, and interview the facility exceeded its license capacity of 24 beds. Residents #10 and #11 lived at the facility causing a census of 26 residents.

Findings included:

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On at 12:50 PM the Agency received information that a resident (#10) had been moved to a sister facility, Divine Living in Hialeah because a survey was taking place at Salmo 23 Elder Care.

Observations at Divine Living in Hialeah on at 1:24 PM found Resident #10 sitting on a bench with Resident #11.

On at 1:27 PM Resident #10 stated, "I live at another facility. They brought me today to pick up some clothes that I left here. I do not remember how many days I have been living at the other facility; the name is Salmo 23. My room is #8. The lady brought me. I live at the other place."

On at 1:55 PM Staff A stated, "Residents #10 and #11 want to live in a smaller home. We took them to Salmo and they liked it better there. We were going to change two residents from Salmo to here. They came to pick up clothes from here. They have been living at Salmo for 4 or 5 days. He asked me to bring him to pick some clothes up."

On at 2:11 PM Resident #11 stated, "We left this home 2 weeks ago. We went to Salmo. I spoke to the owner and told her I wanted to live in a smaller place where I do not have to make a big line to eat and to get my medications. She told me she had Salmo 23 and she took us to see it and we decided to stay there. This morning they told us we had to come here to pick up Resident #10's clothes and they left us here. I saw one of the inspectors at Salmo in the morning. We were in the patio when the other surveyor arrived. I sleep on the first floor with two other residents. We have to wait for them to come pick us up. We left this place 2 weeks ago.

Review of the admission/discharge log at sister facility revealed that Resident # 10 had been discharged on to Salmo 23. Resident # 11 had been on . The demographic sheet of Resident # 10 and # 11 stated that their medications and belongings had been given to Staff A.

Unclassified