STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964471	**11/08/2018**
NAME OF PROVIDER OR SUPPLIER **SOUTHERN HOME CARE MGMT**	STREET ADDRESS, CITY, STATE, ZIP CODE **739 BERNICE COURT** **ORLANDO, FL 32825**	

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

0000 - Initial Comments

A Complaint investigation #2018012121 was conducted on . Southern Home Care Management, license #9011, had deficiencies at the time of the investigation.

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

Based on observations, record reviews, and interview, the facility failed to ensure a health assessment form 1823 was accurate and complete for 1 of 3 sampled residents (#3).

Findings:

Review of the record for resident #2 revealed an 1823 dated and a newer assessment which was not dated. Further review of the record revealed hospital admission and discharge notes which indicated the resident was admitted to the hospital on and discharged on . A new medication list was present which was dated .

On at 2:30 PM, the administrator said the resident had recently been to the hospital and just returned a couple days ago. He confirmed the new health assessment had not been dated by the health care provider.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

An order for 15mg SA, take one tablet twice a day for was present. The MOR and the prescription label read "take one tablet daily."

On at 1:30 PM, the administrator said he could not explain the discrepancies.

3) Review of the record for resident #3 revealed an admission date of . His most current health assessment was not dated, but revealed diagnoses that included ; counseling for . The record documented he was admitted to the hospital for a attempt on and discharged on .

A medication list from the hospital discharge dated 11/6/18 was reviewed. An order for Venflaxine 24hr cap, SA 150mg, take one tablet daily was documented. The MOR and the prescription bottle

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for this medication show 75mg capsule, take one capsule daily and was filled on .

An order or 7.5 mg tablet, take one tablet daily was listed, but was not on the MOR and no medication was present in the facility. Additionally, an order was listed for capsule , 20mg, take one capsule daily, but was not on the MOR and no medication was present in the facility.

On at 2:30 PM, the administrator said he had not reviewed the new medication list and did not know why he did not have the medications.

Class III

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

Based on resident observation, resident record review, medication observation record (MOR) review and interview, the facility failed to maintain current written orders for all medications and failed to maintain all medications in their original containers for 2 of 3 sampled residents (#1 & #2).

Findings:

1) Review of the record for resident #1 revealed an admission date of . The health assessment was dated and revealed diagnoses which included , and an to .

The record revealed on order from the hospice provider dated which read " ( ) 4mg tablet; take 1 tablet orally every day for prevention" A second order for (Warfin) 1mg; take 0.5 tablet orally every day for prevention" was also listed.

There were 3 different vials of ( ) present in the current medication basket for resident #1. The printed pharmacy label on the first vial read 4mg tablet, take 1 tablet by every day to prevent clots. written, on the prescription label, in black marker was "PM 1 tab every Sun, Sat, Tue, Thurs. The other 2 vials both had pharmacy printed labels which read "1mg tab. Take ½ (one-half) tablet (=0.5mg) every day for preventing clots." On one of the vials, written on the prescription label, in black marker was " tab every Sun, Sat, Tue, Thurs. On the second 1mg vial, written on the prescription label, in black marker was "1 tab M, W, F."
Review of the MOR revealed 2 entries for . One read "Take 4.5mg Sun, Sat, Tues, Thu. The MOR had lines and cross-outs, and circled signatures with no explanation. It appeared

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to have been signed as given on and . The second entry read "Take 5mg Mon Wed, Fri." The MOR had lines and cross-outs, and circled signatures with no explanation. It appeared to have been signed as given on and .

On at 11:30 AM, the administrator said he was not sure why there was such a discrepancy with the order and what he wrote in the MOR. He confirmed he made the marker instructions on the vials that changed the dose that was ordered. He said he could not explain why.

2) Review of the record for resident #2 revealed an admission date of . A health assessment dated documented diagnoses which included Non- Lymphoma ( ).

Review of the MOR revealed 8mg tab, take one three times daily as needed for . It was listed with "discontinue" handwritten across the dates. No doses were shown as given in MOR documents medication was discontinued on per verbal order from the social worker.

On at 1:20 PM, the administrator stated the social worker told him verbally on to stop the medication. He confirmed he did not have a written order from a licensed healthcare provider.

Class III

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on observations, record reviews, and interview, the facility failed to ensure the resident contract was signed by a legal power of attorney (POA) and failed to have POA documentation on record was accurate and complete for 1 of 3 sampled residents. (#3)

Findings:

Review of the record for resident #2 revealed an admission date of . The residency agreement was not signed by the resident, but was signed on by a third party. No POA documentation was found in the record.

On at 2:30 PM, the administrator said the resident's sister signed the contract. He confirmed he did not have documentation that she was the resident's legal Power of Attorney.

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Class

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on facility record review and interview, the facility failed to ensure the Comprehensive Emergency Management Plan (CEMP) for the facility was approved by the county Office of Emergency Management on an annual basis as required by 58A-5.026(2) FAC.

Findings:

Request to review the facility's CEMP and approval letter revealed there was no approval letter received.

On at 10:30 AM, the administrator stated he had submitted their plan for approval but did not have a current approval letter from the county.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on facility record review and interview, the facility failed to have an approved Emergency Power Plan (EPP), did not have written policies and procedures available for review and did not, within five (5) business days, notify each resident and the resident's legal representative in writing when the plan was submitted to the county Office of Emergency Management (OEM) for review and approval as required by 58A-5.036 FAC.

Findings:

Review of the facility documents did not find an emergency power plan approval letter. No policies are procedures were provided when requested for review. No documentation the residents or responsible families were notified in writing of the submission of the facility plan was available in the facility or resident records.

Upon request to review the EPP approval plan and letter from the county OEM, on at 12:15 PM, the administrator stated the plan had been submitted and he just received an invoice to pay the county for the approval letter. He confirmed he did not have an approval letter on the day of the visit. He also confirmed he had not sent notification letters to the residents/responsible parties of the plan submission to the county.

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