STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910890	R 12/21/2018
NAME OF PROVIDER OR SUPPLIER **CARE AND LOVE RETIREMENT HOME, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **642 EAST 21ST STREET** **HIALEAH, FL 33013**	

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

0000 - Initial Comments

A Standard Biennial Survey revisit was conducted on - . Care and Love Retirement Home had deficiencies identified at the time of the survey:

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

Based on record review and interview, the facility failed to ensure that Medication Observation Records (MOR) for three out of seventeen sampled residents included Residents' physician information and (13, 14 and 15) .

Findings included:

Observation on at 10:00 am revealed that Staff D searched through Residents 13, 14, 15, 16 and 17's files; however, she could not find or physician information.

Record review revealed that Resident 13's MOR was missing information.

Record review revealed that Resident 14's MOR was missing physician information.

Record review revealed that Resident 15's MOR was missing information.

Record review revealed that Resident 16's MOR was missing and physician information.

Record review revealed that Resident 17's MOR was missing and physician information.

Interviewed on at 10:00 am, Staff D acknowledged that Residents 13, 14, 15, 16 and 17 MORs were missing information.

Uncorrected
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 ensure 1 of 13 (G) sampled staff received 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The facility also failed to provide documentation

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that 1 of 13 (I) sampled staff received 4 hours of initial education training on providing assistance with self-administration of medication.

Finding included:

A review of Staff G's file (hired) revealed no documentation of 2 hours of medication training . Staff I's file did not have documentation of 2 hours of additional training to address regulatory requirements updated as of .

Observation on at 1:00 pm revealed Staff D searching through Staff G's and I's files for documentation of the missing medication trainings; however, Staff D could not find them.

Interviewed on at 1:10 pm, Staff D acknowledged that the files for Staff I and G were missing those trainings.

Uncorrected
Class III

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

Based on observation and interview, the facility failed to maintain appurtenances in good working order.

Findings included:

Observation on at 9:00 am revealed:

- # had no closet or nightstand and the wall painting was peeling.
- # had no closet.
- # had a loose mirror standing against the wall and on top of the wardrobe.
- # 's floor (at front) was loose and broke, and residents did not have nightstand.
- #. had two residents, but had one closet and one wardrobe. It did not have nightstand.

The eating area had a gap on the floor between the tiles.
Bathroom #3 it was missing a light switch the cover.
The facility had a blue tarp on top of the roof and a tie from the roof to the iron fence to keep the tarp in place.
The laundry area had leaking pipes, draining foul odored water into the area.

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SUMMARY STATEMENT OF DEFICIENCIES
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Interviewed on at 9:30 am, Staff D acknowledged that the facility needed repairs.

Uncorrected
Class III

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

Based on record review and interview, the facility failed maintain an accurate record for six of six (#s 6, 8,15,16 and 17) sampled residents.

Findings included:

Record review revealed that Resident 6's observation log did not have hospitalization information ( ). The resident went to the hospital a day earlier due to .

Record review revealed that Resident #8 went to hospital due to , but no observation log note was found in the resident's file.

Review revealed that Resident #15 went to the hospital voluntarily because she was aggressive. Resident 15's observation log did not have hospitalization information.

Review revealed that Resident 16's observation log did not have hospitalization information from the prior week.

Review revealed that Resident 17's observation log did not have hospitalization information.

Interviewed on at 12:45 pm reveals that Staff D stated "Resident #16 went to the hospital last week due to fatigue, and he is doing okay. Resident #17 came from hospital on Friday ( ) because she had ."

Interviewed on at 12:45 pm Staff D stated, "We have a staff to put the information in the computer, and I was on my way to call him to provide each residents hospital information, in order, he put the information." Staff D stated, "We needed to update the information."

Uncorrected
Class III

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SUMMARY STATEMENT OF DEFICIENCIES
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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 a 1 day and 15 day completed adverse incident reports for one of twelve (#9) sampled residents. The resident left the facility and did not return, and the event was reported to law enforcement.

Record review revealed that Resident #9 was admitted on . The Resident Observation Log dated stated, "Resident leaves the facility and we reported to the police." A police report was found in the file case card dated at 2:20 PM for Incident- Missing adult.

Further record review revealed that Resident #9's health assessment (dated) reflected diagnoses of major . The facility did not identify Resident #9 as at risk for elopement.

A review of the Adverse Incident database revealed that the facility did not file an incident report to the Agency after Resident #9 eloped from the facility, and a police reported was done. Resident #9's elopement event ended when the police found him walking on the street and took him to the hospital. He knew the place and the police called the facility.

Interviewed on at 9:30 am Staff D stated, "We did not file an adverse incident report".

Interviewed on at 1:00 pm Staff M stated, " The facility did not file an adverse incident report to the Agency, due to we do not consider Resident #9 as an elopement because he left the facility, and we followed the procedure."

Uncorrected
Class III