STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967063	**12/20/2018**
NAME OF PROVIDER OR SUPPLIER **GOOD STAND HOME CARE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **721 NW 13 AVENUE** **MIAMI, FL 33125**	

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

0000 - Initial Comments

A Standard Biennial Survey was conducted on , 2018 through . Good Stand Home Care, Inc. with a Limited Mental Health component license number 11262, had the following deficiencies identified at the time of survey:

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

Based on record review and interview the facility failed to ensure that one of seven sampled residents (Resident 2) met continued residency criteria and did not require 24 hours nursing.

Findings included:

On , at 10:59 AM, observed a home health nurse enter the facility and state, "I am here for Resident 1 who needs and for Resident 2 who has a , tube to the ."

Review of the Florida Health Finder database showed the facility had a standard license with a limited mental health component.

Review of Resident 2's record showed admission on . The last health assessment dated showed diagnoses of , tube placement, D deficiency, . The resident was independent on all daily living activities, but needed medication administration for , care.

Review of facility's home health record showed Resident 1 had a , tube for the left since . On the resident had with results of , decreased in size with small hyperechoic focus suspicious of stones in left , one at middle region measuring .66 cm and the other one at the lower region measuring .35 cm.

Class III

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

Based on record review and interview, the facility failed to provide adequate supervision by not knowing the whereabouts of one of seven sampled residents, (Resident 1). The resident was found disoriented in a nearby store and brought to the facility by the police.

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Review of Resident 1's progress notes showed the resident went to the corner store and did not come to the facility on . Review of the agency's incident reporting database showed the facility did not send a report about the incident to the state.

Review of the resident's record showed Admission . The last health assessment dated showed Diagnoses of Acute Prostatic Hyperplasia, , History of Type II, , Essential tremor, . The resident was not identified as an elopement risk and was listed as independent in all daily living activities.

Progress notes from the resident's record on stated "Resident is getting worse every time, and now his is much worse and sometimes he does not recognize where he is or the day or his date of birth is. Family knows this already, and we only can supervise him for any change. Social worker knows also his assessment. Resident usually goes to the corner cafeteria to get a colada and then come ; that is the only thing he does every day." Further review showed progress notes stated "Today I received a call from the employees at 5:50 PM saying that Resident 1 went out since 4:45 PM and he had not returned yet. Well, I call his family member to see if he was with them but he was not, so I came to the facility and the police had him and he was in the corner at seven eleven. Called the family and let them know that he is Ok at home already. Since now on, he needs more supervision and he cannot go out for anything."

Review of the facility's elopement policy and procedures showed the following steps:
Call 911
Inform administrator or person in charge.
Fill out adverse incident report Day 1 and fax to agency within 24 hours.
15 Days after incident, file report Day 15 and fax to agency
An elopement attempt will also be documented and copies of reports Day 1 and Day 15 incident reports will be kept on file.

On , at 2:21 PM, the Administrator stated, "No one has eloped from the facility, thank God."

On , at 3:20 PM, the Administrator stated, "I told Children and Families that he was at the and the employee there is the one who called the police. He went from the gas station to the for . When the police brought him here, they had already called Children and Families. I purchased 100 wristbands with the facility information for everyone and they all wear it. He went to the doctor and the doctor did another health assessment, added on the diagnoses and medication. He just

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does not go out by himself anymore."

On , at 12:15 PM, the Administrator stated, "I understand that elopement is when the resident intentionally leaves the facility and does not come ; that is why it was not reported. What happened in the past it was in 2016 and we found him right away."

Class III

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observation and interview, the facility failed to follow the procedure outlined by the state when assisting with self-administration of medications for one of seven sampled residents (Resident 3).

Findings included:

On , at 7:25 AM, observed Staff E get the Medication Observation Record (MOR), wash her , take cup and water, put on new gloves, get resident and ask him to sit down and take cup of water. Staff open locked medication cabinet and got medications for the resident, punched the medications out of the cards into her and put the tablets inside a small cup. Staff E then asked the resident to take the medications, verbally identifying only one of the medications. When finished, the staff took the gloves off and put all medication cards inside the cabinet and locked it, then, initialed all medications given on the MOR.

On , at 12:15 PM, the Administrator acknowledged the deficiencies and stated that he would start making the corrections.

Class III

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

Based on observation and interview, the facility failed to ensure that medications were securely stored .

Findings included:

On , at 7:20 AM, observed in shared resident # , two containers of prescribed Cream 2% on top of the nightstand. Staff C acknowledged the issue and stated that she knew

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that the medications were not supposed to be on the table.

Class III

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

Based on observation and record review, the facility failed to ensure that Over the Counter Medications (OTC) were labeled for one of seven sampled residents (Resident 5).

Findings Included:

On , at 7:40 AM, observed inside the refrigerator located inside the locked office, Resident 5's OTC Suppositories. Medication was not labeled with the resident's information.

On , at 7:40 AM, Staff C stated, "This is for Resident 5, she insist that she cannot go to the bathroom so the doctor prescribed the over the counter."

Class III

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

Based on observation, record review and interview, the facility failed to provide proof of the required pre-service orientation training for two of six sampled staff (Staff E and F). New staff must complete the orientation prior to interacting with residents.

Findings included:

Review of Staff E's record showed hire date as caretaker and Staff F's hire date as caretaker. The staff schedule showed both staff assigned to work at least 8 hours per day.

On , at 12:15 PM, the Administrator acknowledged the deficiency and stated that he would start making the corrections.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on record review and interview, the facility failed to note changes in the menu before or when

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meal was served for breakfast. In addition, the facility failed to remove expired food cans from the stored 3-Day emergency supply.

Findings included:

On , at 7:20 AM, observed inside the food storage room, Del Monte leaf spinach 13 oz can with expiration date , Great Value mixed vegetables 13 oz can with expiration date and Harvest Blends Cream of Chicken can with expiration date . The cans were removed by the staff and stated that they were always checking the dates.

Review of the facility's approved menu showed for breakfast on , assorted juices, dry or hot cereal, bread, margarine and milk. The residents at 7:45 AM were seated at the dining table having breakfast which consisted of cheese and mayonnaise sandwiches or ham and cheese sandwiches with milk, chocolate milk or water.

On , at 7:45 AM, Staff C stated, "I always ask them what they want to eat."

Class III

0125 - Fiscal - Surety Bonds - 429.27(2) FS; 58A-5.021(3) FAC

Based on record review and interview, the facility failed to maintain a surety bond with the agency in an amount equal to twice the average monthly aggregate income or personal funds.

Findings:

On , at 7:50 AM, Resident 5 stated that the facility was receiving directly her $38 and that she would ask the Administrator to get what she needed for her. The Administrator acknowledged receiving the money and keeping receipts of all purchases. He also acknowledged that the facility received the income for Resident 2 from social security.

Review of the facility's records showed no documentation of a surety bond.

Review of Resident 5's record contained a copy of all purchases made for Resident 5.

On , at 9:22 AM, the Administrator stated, "We receive social security directly for Resident 2. I already purchased the insurance."

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Class III

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

Based on record review and interview, the facility failed to report within 1 business day after the occurrence of the adverse incidents and a full report within 15 days to the agency including the results of the facility's investigations into the adverse incidents for one of seven sampled residents (Resident 1). Resident at the facility in the month of , had a cut on his and was transferred to the doctor's office. The same resident left the facility in , 2018 for the store and did not go until a store employee called the police.

Findings included:

Incident 1) Review of the resident's record showed Admission . Last health assessment . No . Diagnoses Acute , , Prostatic Hyperplasia, , History of , , Type II, , , Essential tremor, , . The resident was not identified as an elopement risk and was independent in all daily living activities.

Progress notes in Resident 1's record dated showed: "Resident was in bed and employee went to wake him up at 11:30 AM and when he was going to stand up from bed, he rolled over and on the floor. He just got his point cut and a little but, the next day his left turned purple. He went to the program immediately where his doctor is and was attended by the doctor." Progress notes on stated "Resident is much better today."

A review of Doctor's progress notes dated showed: "Administrator stated that resident got tangled up in bed sheet and out of bed on around lunchtime. The Administrator heard noise like someone falling out of bed and found resident on the floor. Community nurse checked the resident yesterday and this morning. Here for exam. Resident remembers falling out of bed and hitting night table, put his out and that is what hit his left ." around left upper , near vision intact with jaegar chart, right has clouding of lens, no , no injection, slight tenderness to palpation around orbit, no deformity. On skin, superficial on left second , approximated, clean and dry, no or drainage. Diagnosis, community nurse to dress superficial daily and continue to check and will titrate as needed. Prescribed on , instill 1 drop by , ( ) route in each 2 times per day".

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Incident 2) Review of Resident 1's progress notes on record showed the resident went to the corner store and did not come to the facility on . Review of the agency's incident reporting systems showed the facility did not send a report.

Progress notes in Resident 1's record dated showed "Resident is getting worse every time, and now his is much worse and sometimes he does not recognize where he is or the day or his date of birth is. Family knows this already, and he only can supervise him for any change. Social worker knows also his assessment. Resident usually goes to the corner cafeteria to get a colada and then come that is the only thing he does every day."
Further review showed progress notes stating "Today I received a call from the employees at 5:50 PM saying that Resident 1 went out since 4:45 PM and he had not returned yet. Well, I call his family member to see if he was with them but he was not, so I came to the facility and the police had him and he was in the corner at Seven Eleven. Called the family and let them know that he is Ok at home already. Since now on, he needs more supervision and he cannot go out for anything."

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On , at 12:15 PM, the Administrator stated, "I understand that elopement is when the resident intentionally leaves the facility and does not come ; that is why it was not reported."

Review of the incident report database showed required incident reports were not submitted.

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Class III

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(9) FAC

Based on record review and interview, the facility failed to provide documentation of a minimum 6 hours limited mental health training for one of six sampled staff (Staff D). Staff who have direct contact with mental health residents.

Findings included:

Review of the facility's record on Florida health finder showed the facility with a Limited Mental Health component. Review of Staff D's record showed hire date and the facility's staff schedule showed Staff D working during the night on the weekends.

On at 12:15 PM, the Administrator acknowledged the deficiency and stated that the only approved provider for the training did not have any until .

Class III