STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964927	R 01/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND RETIREMENT SENIOR HOME	**3508 SW 26 STREET MIAMI, FL 33133**

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

0000 - Initial Comments

An Abbreviated Biennial Revisit Survey was conducted on 01/14/2019 and concluded on 01/23/2019. Richland Retirement Senior Home had deficiencies identified at the time of the survey:

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

Based on record review and interview, the facility failed to provide care and offer personal supervision appropriate to the needs of one out of eleven (Resident #8) sampled residents. The facility failed to notify the family member and doctor for one out of eleven (Resident #8) sampled residents. The facility did not document any significant changes or incidents for a resident who was transferred to the hospital by a family member for one out of eleven (Resident #8) sampled residents.

Findings Included:

Resident #8's health assessment date documented a medical history of 's, type 2, and Hyperkeratosis. The resident needed supervision with toileting and transferring and needed assistance with the rest of the activities of daily living. The resident was under precautions. Progress notes document Resident #8 lost balance and hit in the forehead on at 10:45 AM. Resident #8's son decided transferred her to the hospital on at 10:10 AM.

Hospital record review revealed Resident #8 was brought to the hospital on for evaluation of . The record document that the resident getting up from bed tripped and two days ago. The resident had to her right , right arm and under .

Interview conducted on at 6:25 AM, Staff C stated Resident #8 was hospitalized on and did not return. She was living with her family member at this time. Resident #8 stand up from her chair and hit her against the wall. We called 911 and she was evaluated. They decided that she did not need to be transfer to the hospital. Her son came next day and decided to take her to the hospital.

The facility did not have any documentation that they contacted Resident's #8 family members and physician after the resident's on .

Class III

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Uncorrected

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

Based on observation and record review, the facility failed to follow procedures when assisting with medication to three out of eleven (Resident #4, #7 and #13) sampled residents.

Findings included:

On at 6:04 AM Staff C assisted Resident #4 with his medications. She took one tablet of 81 MG, 800 mg, SOD 10 mg, D 50,000U, 10 mg, and 20 mg out from the package and put them in a cup. She walked to the dining area and gave the cup to the resident. Medication Observation Record was not initialed after medications been given.

On at 6:16 AM Staff C assisted Resident #7 with her medications. She took one tablet of ER 650 MG, 325 mg, 1 mg, 100 mg, 850 mg, SOD DR, 1,000 MCG, 100 mg, 81 mg, and 10 mg out from the package and put them in a cup. She walked to the dining area and gave the cup to the resident. Medication Observation Record (MOR) was not initialed after medications been given.

On at 6:40 AM Staff C assisted Resident #13 with his medications. She took one tablet of 10 mg, Succ ER 50 mg. and 300 mg, and 50 mg out from the package and put them in a cup. One tablet on the floor, Staff C observed it and thought it was not seen and dragged it under her . She walked to the dining area and gave the cup to the resident. The medication that on the floor was 50 mg. At 6:45 AM she was told that the medication on the floor and the resident needed to receive it, she took the medication from the bingo card with her bare and brought it to the resident.

On at 7:07 AM Staff C initialed the MOR before giving the morning medication to Resident #10.

Class III
Uncorrected

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

Based on record review and interview, the facility failed to maintain an accurate daily medication

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observation record (MOR) for each resident who received assistance with self-administration of medications for eleven out of eleven sampled residents.

Finding included:

Record review showed that the facility staff did not initial the MOR since at 8:00 AM. The pills from to were removed from the bingo cards.

Observation on at 6:27 AM showed Staff C was initialing all the MORS from to .

Interview conducted on at 6:09 AM, Staff C stated that the MOR was lost since Friday afternoon, and that is why they did not initial it. She reported she gave all the medications to the residents.

Staffing schedule review showed Staff C only worked from 6:00 AM to 6:00 PM on and , and she was off on Sunday .

Class III

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

Based on record review and interview, the facility failed to maintain the directions for use "as needed" prescription for two out eleven (Resident #4 and #7) sampled residents.

Findings included:

Medication Observation Record (MOR) review showed the physician prescribe , 800 mg as needed for Resident #4 and ER 650 MG as needed for for Resident #7.

There was no documentation of the circumstances under which it would appropriate for the resident to request , 800 mg for Resident #4.

On at 6:04 AM Staff C assisted Resident #4 with his medications. She took one tablet of 800 mg out from the package and put it with the rest of the medications in a cup. She walked to the dining area and gave the cup to the resident. Resident #4 did not request the medication.

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SUMMARY STATEMENT OF DEFICIENCIES
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On at 6:16 AM Staff C assisted Resident #7 with her medications. She took one tablet of ER 650 MG, out from the package and put it with the rest of the medications in a cup. She walked to the dining area and gave the cup to the resident. Resident #7 did not request the medication.

Class III

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

Based on observation, record review, and interview, the facility failed to maintain the employee roster in the Background Screening Clearinghouse Database.

Findings included:

On at 5:25 AM Staff G hired on was observed in the facility providing services to residents.

A review of the facility's roster in the Background Screening Clearinghouse Database showed that Staff G was not listed, and Staff F and H were listed.

Interview conducted on at 6:33 AM, Staff C stated that Staff H did not work in the facility since last month or the previous one. Staff F terminated in .

Unclassified