STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953342	01/31/2019
NAME OF PROVIDER OR SUPPLIER **PROFESSIONAL HOME CARE III, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **447 EAST 26 STREET HIALEAH, FL 33013**	

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

0000 - Initial Comments

A standard biennial survey was conducted on in conjunction with a limited nursing services monitoring survey. Professional Home Care III, Inc. with limited mental health and limited nursing services components had the following deficiencies identified at the time of the survey:

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

Based on observation, record review, and interview, the facility failed to maintain an updated written record for two out of 20 sampled residents (#3 and #2). Resident #3 had a bunion and there was no documentation that he received services of a podiatrist. There was no documentation regarding Resident #2's behavior or that the facility informed his primary care physician.

Findings included:

1. Observations during the tour on at 7:30 AM found Resident #3 sitting at the outside area.

Interview on at 7:30 AM Resident #3 stated, "I have on my left . I have a bunion that is causing (left). I had communicated to staff but I am still on ."

Record review revealed Resident #3's progress notes did not have any written information regarding the resident's or care from a podiatrist.

Interview on at 2:10 PM Staff A stated Resident #3 did not tell her about the bunion. In addition, Staff A stated that Resident #3 had podiatrist to take care of his nails, and the physician had never mention anything about his bunion.

2. On observed Resident #2 in the outside area with his on the ground and his down and drooling saliva from 7:41 AM - 7:50 AM. Resident #3 and # 8 stated Resident #2 usually sat on his most of the time. Further observation revealed Staff B, E, K and I arrived and assisted Resident #2 to sit on the wheelchair.

On at 7:52 AM, Staff I offered Resident #2 to stood up and that they would give him a coke if he did so. Staff B brought a bottle of Diet Pepsi and showed it to Resident #2. He assisted and cooperated while staff helped to sit in the wheelchair. Resident #2' had a to the left .

On at 7:51 AM, as per Staff B, E, K and I "Resident #2 is always like that during morning time,

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at daytime, after lunch time, he will be doing well."

Review of Resident #2's record showed that the last progress note was . The progress notes from to did not show that the resident presented that behavior before or that the facility informed the doctor or the home health nurse about it.

Class III

0026 - Resident Care - Social & Leisure Activities - 58A-5.0182(2) FAC

Based on observation, record review, and interview, the facility failed to follow the facility's activity scheduled posted on the board.

Findings included:

Observation on from 6:45 AM - 2:30 PM revealed that the facility did not provide any activities to the residents. The facility did not encourage the residents to participate in any activities.

Record review revealed that the facility's activity scheduled reflects activities 2:00 PM - 4:00 PM (Bingo).

Interviews on from 6:45 AM - 2:00 PM revealed that Residents stated there was nothing to do in this facility, and they did not have activities. In addition, a family member interview revealed that the facility did not offer any activities to the residents.

Interview on at 2:00 PM Staff A acknowledged that the facility was not providing activities to the residents.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Base on observation, interview, and record review, the facility failed to honor resident rights. They failed to ensure that residents were treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy for three (Residents #6, #7, and #10) out of 20 sampled residents.

Finding included:

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1) Observation on at 6:49 AM revealed the facility had a census of 23 residents, and three staff (B, E, and I) on site to assist the residents with their shower, medication, and breakfast.

Observation on at 6:58 AM, while touring the facility, revealed Resident #6 having a shower while the doors were open. Resident #6 was naked in the shower in the bathroom. Further observations on at 7:25 AM revealed Resident #3 (naked) in the bathroom with the door open.

During an interview on at 1:00 PM Staff A and G stated, "Our staff know that they cannot do that."

2) On at 7:13 AM, Resident #19 sitting on one of the beds in # .

On at 7:13 AM, Staff B revealed Resident #19 sat on Resident #20's bed. Staff assisted Resident #19 to get out of the bed but Resident #19 's clothes were wet.

Class III

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

Based on record review and interview, the facility failed to have a two hours pre-hiring orientation training for 1 (J) of 10 sampled staff.

Finding included:

Record review revealed Staff J (hired) did not have the two hours of pre-hiring orientation training in file signed per Staff A.

Interview on at 1:00 PM Staff A acknowledged that Staff J did not have that training properly signed in file.

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 have a surety bond with the agency in an amount equal to twice the average monthly aggregate income which included Supplemental Security Income (SSI) or Social Security , Income (SSDI) or personal funds due to residents, or expendable for their account, which are received by a facility.

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Findings included:

The facility had a surety bond effective on . . . . . for $9000.00.

The facility was the payee for six residents for the total amount of $4,700.
- The facility received a check under the name of the Assisted Living Facility (ALF) for Resident #10. It showed SSI for . . . . , , dated . . . . . for $751.00.
- The facility received a check under the name of the Assisted Living Facility (ALF) for Resident #17. It showed Soc Sec for . . . . . , dated . . . . . for $522.00.
- The facility received a check under the name of the Assisted Living Facility (ALF) for Resident #2. It showed Soc Sec for . . . . . , dated . . . . . for $819.00.
- The facility had a bank account in conjunction with Resident #15. The account received a deposit from SSA (Social Security Administration) on . . . . . for $1045.00.
- The facility had a bank account in conjunction with Resident #12. The account received a deposit from SSI on . . . . . for $91 and another deposit on . . . . . for $701.00.
- The facility had a bank account in conjunction with Resident #8. The account received a deposit from SSI on . . . . . for $771.00.

On . . . . . at 2:10 PM, Staff G revealed that she thought the surety bond for $9000 was enough. Residents' checks sometimes changed.

Class III

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

Based on observation and interview, the facility failed to maintain a safe living environment for a census of 23 residents.

Findings included:

Observation on . . . . from 6:45 am - 11:00 am revealed that the facility had the following:

1- The facility had a big bathroom that the light was not working.
2- Residents were having shower with sheets on floor and wet floor one by one, with no replacement of the sheets
or cleaning the floor.

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3- # # had a bad odor (and feces).
4- # had broken skirting behind the bed
5- The small bathroom was dirty, had on the floor and the toilet top broke.
6- # had scratch wall next to the bed (B).
7- # had a fan, and it sound loud constantly.

On at 7:05 AM, # had a strong smell and the linen of one of the beds in the room was .

Interview on at 2:00 PM Staff A and G stated that they will talk with staff and they will fix the facility as it required.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview, the facility failed to identify or home address to which the resident was discharge for one out of 20 sampled residents (#18).

Findings included:

Review of the admission and discharge log showed Resident #18's discharge date was on . It showed that she moved out to "Nursing home".

On at 2:07 PM, Staff G acknowledged that the facility needed to work in the admission and discharge log.

Class III

L241 - LMH - Records - 429.075( ); 58A-5.029(2) FAC

Based on interview and record review, the facility failed to clearly identify mental health residents in the admission and discharge log for two out of 20 sampled residents (#2 and #11).

Findings included:

On at 9:58 AM, Staff G revealed that Residents #2 and #11 received (,) and SSI (Supplemental Security Income) due to a mental condition.

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Review of the admission and discharge log showed the facility did not identify Residents #2 and # 11 as limited mental health.

Class III

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Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on observation, record review, and interview, the facility failed to have a level 2 background screening for one out of 11 sampled staff (K).

Findings included:

On at 7:47 AM, Staff K was in # with no other staff around while she fixed the bed for Resident #15. Resident #14 rested in her bed in # while Staff K was in the room by herself.

Record review revealed the facility did not have a level 2 background screening for Staff K.

Interview on at 1:00 PM Staff A and G stated, "Staff know that Staff K is just a volunteer from school, and she must not left alone with any of the residents."

Unclassified deficiency