STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966015	**02/13/2019**
NAME OF PROVIDER OR SUPPLIER **ADVANCED ALF CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **14335 SW 288 STREET** **HOMESTEAD, FL 33033**	

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

0000 - Initial Comments

A Standard Biennial Survey was conducted on [redacted] to [redacted]. Advanced ALF, Corp. with Limited Mental Health component license, had the following deficiencies identified at the time of 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 progress notes for two of seven residents (Residents #2 and 6) who had a significant change. Resident # 2 was taken to the hospital for [redacted] from a hole in his lower abdomen. Resident #6 got lost when going [redacted] to the facility from a medical procedure.

Findings included:

Review of the facility's admission and discharge log showed Resident #2's admission date as [redacted] and for Resident 6, [redacted].

A) On [redacted], Staff C stated that Resident 2 was at the hospital due to [redacted] from the lower side of the body. Review of the admission/discharge log showed resident admission date [redacted]. Review of resident's record showed no documentation of the hospitalization. Staff B stated that the resident was taken to the hospital and that the hospital might put a [redacted]. She said that at admission, the resident did not have a [redacted] and neither the facility or his guardian were aware of any tube; that the resident was eating normal food. A review of the health assessment showed that the resident needed a mechanical soft diet (mechanical soft is described as food that does not require a lot of chewing).

Hospital record review showed Resident #2 was hospitalized on [redacted], a week after he was admitted (on [redacted]) and on examination was found to have a hole in his abdomen where a [redacted] should have been. The [redacted] was [redacted], and the resident had a fecal impaction. According to the health assessment, the resident needed a mechanical soft diet, and ALF staff was unaware of this, so the resident had been receiving regular food. A review of the ambulance run record showed that the ALF staff informed [redacted] that they'd noticed two days earlier that the resident's [redacted] had been dislodged.

B) On [redacted], at 1:04 PM, Staff C stated, "Resident 6 got lost once. Maybe three months ago. The car left him some place else and did not know how to come [redacted], but the police was called already.

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The police brought him."

On , , at 12:40 PM, in reference to Resident 6, Staff B stated, "He is a , patient and when he finished his treatment, the place sent him on Uber and he asked the Uber driver to drop him off someplace else and got lost. We called the police and was brought to us when they found him."

Class III

0027 - Resident Care - Arrangement for Health Care - 58A-5.0182(3) FAC

Based on record review and interview, the facility failed to arrange health care services to one of seven sampled residents (Residents 2). Resident 2 was taken to the hospital with an hole in his abdomen, and fecal impaction.

Findings included:

Review of facility's admission/discharge log showed Resident #2 was admitted and discharged to the hospital on .

On , , , Staff C stated Resident #2 was at the hospital due to from the lower side of the body.

A review of the ambulance run record showed that the facility staff informed the paramedics that they had noticed two days earlier that the resident's had been dislodged. A review of the hospital record showed Resident #2, on examination found to have a hole in his abdomen where a should have been. The was , and the resident had a fecal impaction.

On , , at 8:45 AM, Staff B stated the resident was taken to the hospital and that the hospital might put a . She said that at admission, the resident did not have a and that the resident was eating normal food. A review of the health assessment showed that the resident needed a mechanical soft diet (mechanical soft is described as food that does not require a lot of chewing).

Review of the resident's health assessment dated documented a medical history of , injury, , , retention, and , unspecified abnormalities of gait and mobility, , . Assistance with most activities of daily living. According to the health assessment, the resident needed a mechanical soft diet, and the facility staff was unaware of this, so the

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resident had been receiving regular food. The record showed no documentation of notes related to any difficulties the resident had while living at the facility.

Class II

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

Based on record review and interview, the facility failed to provide health care services consistent with established and recognized standards for one of seven sampled residents (Resident 1), who became unresponsive and at the facility. Staff did not perform , , ( ) for a resident who did not have a ( ) in place.

Findings included:

Review of admission/discharge log showed, Resident #1's admission and discharged due to ; place discharged, to Funeral Home.

On , , at 7:50 AM, Staff C stated, "Resident #1 had issues; he went to the hospital for a procedure and when came , 5 days later, he passed here." Staff C stated that on the day of his , she was alone at the facility with all residents and the resident asked her to call 911, that he did not feel good and thought he was dying. Staff C stated she called 911, sat the resident comfortably and went to the kitchen to bring him water. When she went to see the resident, he was unresponsive. She stated she did not perform , and that the rescue arrived and told her he was , and took him."

Review of Staff C's personnel record did not show training. Further review showed valid documentation of training, which Staff C had completed on and which expired on .

Review of Resident 1's record showed that he was admitted to the facility on , and on . Last health assessment dated showed the resident was wheelchair and bed bound with a medical history and diagnoses of , in native , and of without pectoris. Assistance with most activities of daily living and total with ambulation. Progress notes for stated, "Today, the resident after he had dinner stated that he had lack of air and asked the staff to call 911; the staff followed the instructions that they gave her; when they arrived, they gave him first aid and transferred him to the hospital. After few hours, a Dade County police came to communicate that the resident had passed."

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Review of the Ambulance Run Record from Emergency Services showed that paramedics arrived 6 minutes after Staff C placed a call to 911. The record showed, "Upon arrival, patient found unresponsive. Pulseless with agonal . Patient was , and pupils were unresponsive. Patient was , ( ) on the monitor. protocol followed with no improvements. performed for 20 minutes on scene and then transported to hospital with no improvements."

Facility record review showed no documented policy or procedures regarding . On , at around 10:00 AM, observed the Administrator and Owner of the facility contact the previous owner regarding policies and procedures, who advised them to check the shed located outside on the backyard. Review of the facility's records for Residents # 1,2,3,4 and 5 showed that no resident had a in place.

In reference to procedures when a resident has a health emergency, Staff C stated, "I call 911 first, if they ask me, I give them ."

Class I

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(I)

Based on record review and interview, the facility failed to assess two of seven sampled residents (Resident 2 and 6) with risk for elopement or past elopement, and failed to implement precautions against further risk. Resident #2 away when returning from a medical , became lost, and was found by the police. The facility also failed to conduct a minimum of two resident elopement prevention and response drills per year.

Findings included:

1) On , at 12:40 PM, Staff B stated, "Resident 6 is a patient and when he finished his treatment, the place sent him on a private transportation and he asked the driver to drop him off someplace else and got lost. We called the police and was brought to us when they found him."

Review of Resident 6's record showed a health assessment dated stating the resident was not elopement risk. There was no documentation of a new assessment having been conducted after the resident away, and no record of safety precautions taken in case the resident again was found.

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2) Review of Resident 2's health assessment dated revealed that the resident was considered to be at elopement risk. A photo of the resident was not found in the record. Interviewed during the inspection on , Staff B was not aware that the resident was elopement risk.

Review of the facility's elopement policy, procedures and drills showed drills conducted , , . There was no documentation of two drills conducted in 2018, or drills conducted in 2019.

Class III

0076 - ( ) - 58A-5.0186 FAC

Based on record review and interview, the facility failed to provide ( ) to a resident who at the facility and did not have a ( ) in place. The facility failed to provide documention of a policy or procedure regarding . One of three sampled staff, who works alone at the facility, failed to demonstrate understanding of procedures, and there was no documentation that the staff had been trained regarding (Staff C).

Findings included:

Review of Resident #1's record showed that he was admitted on , and at the facility on . The resident's last health assessment dated showed that he was was wheelchair and bed bound with a medical history and diagnoses of , in native and of without pectoris. Resident #1'Assistance with most activities of daily living and total with ambulation. Progress notes for stated, "Today, the resident after he had dinner stated that he had lack of air and asked the staff to call 911 ; the staff followed the instructions that they gave her; when they arrived, they gave him first aid and transferred him to the hospital. After few hours, a Dade County police came to communicate that the resident had passed." Further review found no documentation of a for Resident #1.

Review of the records for the facility did not show policy and procedures for . On , at around 10:00 AM, when asked to provide the facilty's prolicies and procedures, the Administrator provided a blank resident choice form, used to determine whether residents acknowledged having a or wishing to be . A review of records for Residents #2,3,4,5 and 6 found no

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documentation of or resident choice forms. On , at around 10:00 AM, observed the Administrator and Owner of the facility contact the previous owner by telephone regarding policies and procedures, who advise them to check for an old policy predating the sale of the assisted living facility the shed, located outside in the backyard.

On , at 7:50 AM, Staff C stated, "Resident 1 had issues; he went to the hospital for a procedure and when came , 5 days later, he passed here." Staff C stated that on the day of his , she was alone at the facility with all residents and the resident asked her to call 911, that he did not feel good and thought he was dying. Staff C called 911, sat the resident comfortably and went to the kitchen to bring him water. When she went to see the resident, he was unresponsive. She stated she did not perform ; the rescue arrived and told her he was , and took him.

On , at 1:04 PM, Staff C stated In reference to which residents had , "No one here has it. I know because I speak with them." In reference to training, Staff C stated that she had all required training. In reference toprocedures when a resident has a health emergency, Staff C stated, "I call 911 first, if they ask me, I give them ."

Class I

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

Based on record review and interview, the facility failed to provide the required dietary needs to one of seven sampled residents (Resident 2), who needed a mechanical soft diet, and whom the facility was providing with regular food. The resident was hospitalized with an unexplained and hole in the and a fecal impaction.

Findings included:

Review of facility's admission/discharge log showed Resident 2's admission and discharged to the hospital on .

On , , Staff C stated Resident 2 was at the hospital due to from the lower side of the body.

Review of resident 2's record showed no progress notes. Staff B stated, "The resident was taken to the

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hospital and that hospital might put a [redacted]." The staff also stated that at admission, the resident did not have a [redacted] and neither the facility or his guardian were aware of any tube; that the resident was eating normal food. A review of the health assessment showed that the resident needed a mechanical soft diet. Mechanical soft is described as food that does not require a lot of chewing.

Hospital record review showed Resident #2 was hospitalized on [redacted], and on examination was found to have a hole in his abdomen where a [redacted] should have been. The [redacted] was [redacted], and the resident had a fecal impaction. According to the health assessment, the resident needed a mechanical soft diet. A review of the ambulance run record showed that the facility staff informed the emergency ambulance staff that they'd noticed two days earlier that the resident's [redacted] had been dislodged.

Resident #2's health assessment dated [redacted] documented a medical history of [redacted] injury, [redacted], retention, [redacted] and [redacted], unspecified abnormalities of gait and mobility, [redacted]. The resident needed assistance with most activities of daily living, was self-propelling in a wheelchair and independent with eating. Special diet: Mechanical soft diet. [redacted] or behavioral status: Moderately [redacted] cognition. Physical or sensory limitations: Decreased functional mobility.

On [redacted] at 8:23 AM, in reference to meals served to Resident 2, Staff C stated, "In the morning he used to eat coffee and toast; at lunch and dinner time, normal food."

On [redacted] at 8:45 AM, the Owner and Staff B arrived. Staff B stated, "I need to discharge Resident 2; they told me that he needs a tube."

In reference to procedures of resident admission to the facility, Staff B stated on [redacted] at 10:18 AM, "The administrator and I review the papers from the hospital or doctor." In reference on how they communicate any change on diet to the staff, "We tell the staff if they need special diet." In reference of any residents with mechanical soft food, Staff B stated, "No since we started in 2017." Observed the Administrator and Staff B review the health assessment for Resident 2 and realized that it stated, "Mechanical soft food."

Class III

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

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Based on record review and interview, the facility failed to file a surety bond with the agency in an amount equal to twice the average monthly aggregate income or personal funds due to residents, or expendable for their account, which are received by the facility.

Findings included:

Review of facility's records showed no documentation of surety bond for any resident's money received directly under the facility's name.

On at 10:00 AM, when Staff B was asked if the facility received resident payments directly under the facility's name, Staff B stated, "We receive direct payments for Residents 6, 3, 5, 7 and 2. I will take care of the bond as soon as possible."

Class III

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

Based on record review and interview, the facility failed to provide documentation of a signed contract for two of seven sampled residents (Residents #2 and #7). The facility also failed to provide a record for one of seven sampled residents (Resident #1)

Findings included:

1) Review of Residents #2 and 7's records showed admission date and all admission documents not signed by the residents or their legal representatives.

On , at 10:15 am, Staff B stated, "The guardian needs to pass by to sign all the paperwork."

2) Review of the facility's admission and discharge log showed Resident #1 admitted on , discharged on . The reason for discharge was listed as ' ', and the place discharged to as 'funeral home.'

Review of resident records showed that none existed for Resident #1.

On , at 7:50 AM, Staff C stated, "Resident 1 had issues; he went to the hospital for a procedure and when came , 5 days later, he passed here." Staff C stated that on the day

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of his , the resident asked her to call 911, that he did not feel good and thought he was dying.

On , at 7:58 AM, Staff B stated, "We keep old records at the office, not here, I would have to go and get it."

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 incident and a full report within 15 days to the agency including the results of the facility's investigation into the adverse incident for three of seven sampled residents (Residents #1, 2 and 6). Resident #1 became unresponsive and at the facility. Resident #2 was hospitalized for . Resident #6 away while going to the facility from a medical procedure and was found by the police.

Findings included:

1)
Review of facility's admission/discharge log showed Resident #2 was admitted and discharged to the hospital on .

On , Staff C stated that Resident #2 was at the hospital due to from the lower side of the body.

A review of the hospital record showed Resident #2, on examination, was found to have a hole in his abdomen where a should have been. The was , and the resident had a fecal impaction. A review of the ambulance run record showed that the facility 'staff informed them that they had noticed two days earlier that the resident's had been dislodged.

On , at 8:45 AM, Staff B stated the resident was taken to the hospital and that the hospital might put a . She said that at admission, the resident did not have a and neither the facility or his guardian, were aware of any tube; that the resident was eating normal food. A review of the health assessment showed that the resident needed a mechanical soft diet (mechanical soft is described as food that does not require a lot of chewing).

Review of the adverse incident report database showed no documentation of Resident #1's

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hospitalization.

2) Review of facility's admission/discharge log showed Resident #2 was admitted and discharged to the hospital on .

On , Staff C stated that Resident #2 was at the hospital due to from the lower side of the body.

Review of the adverse incident report database showed no documentation of Resident #2's being taken to a higher level of care for a condition which was not related to his known medical issues.

3)
On , at 1:04 PM, Staff C stated, "Resident #6 got lost once. Maybe three months ago. The car left him some place else and did not know how to come , but the police was called already. The police brought him."

Review of Resident #6's record showed no documentation regarding the resident having been lost and brought home by the police.

Review of the adverse incident report database showed no documentation of Resident #6's incidence of being missing.

On , at 12:40 PM, Staff B stated, "Resident #6 is a patient and when he finished his treatment, the place sent him on Uber and he asked the Uber driver to drop him off someplace else and got lost. We called the police and he was brought to us when they found him."

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation and interview, the facility failed to provide documentation of the amount of fuel that needed to be stored onsite to ensure that the room temperature could be maintained at or below 81 degrees for 48 hours in the event of the loss of primary electrical power.

Findings included:

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On [redacted] at 7:30 AM, observed inside a shed located on the backyard of the facility, a portable generator and two five gallon fuel containers.

On [redacted] at 11:45 AM, the Owner stated, "I need to find the manual, I will work on this right away. I also will go to the fire department to find out if they allow gasoline to be stored in the facility."

Class III

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SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

A Standard Biennial Survey was conducted on [redacted] to [redacted]. Advanced ALF, Corp. with Limited Mental Health component license, had the following deficiencies identified at the time of 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 progress notes for two of seven residents (Residents #2 and 6) who had a significant change. Resident # 2 was taken to the hospital for [redacted] from a hole in his lower abdomen. Resident #6 got lost when going [redacted] to the facility from a medical procedure.

Findings included:

Review of the facility's admission and discharge log showed Resident #2's admission date as [redacted] and for Resident 6, [redacted].

A) On [redacted], Staff C stated that Resident 2 was at the hospital due to [redacted] from the lower side of the body. Review of the admission/discharge log showed resident admission date [redacted]. Review of resident's record showed no documentation of the hospitalization. Staff B stated that the resident was taken to the hospital and that the hospital might put a [redacted]. She said that at admission, the resident did not have a [redacted] and neither the facility or his guardian were aware of any tube; that the resident was eating normal food. A review of the health assessment showed that the resident needed a mechanical soft diet (mechanical soft is described as food that does not require a lot of chewing).

Hospital record review showed Resident #2 was hospitalized on [redacted], a week after he was admitted (on [redacted]) and on examination was found to have a hole in his abdomen where a [redacted] should have been. The [redacted] was [redacted], and the resident had a fecal impaction. According to the health assessment, the resident needed a mechanical soft diet, and ALF staff was unaware of this, so the resident had been receiving regular food. A review of the ambulance run record showed that the ALF staff informed [redacted] that they'd noticed two days earlier that the resident's [redacted] had been dislodged.

B) On [redacted], at 1:04 PM, Staff C stated, "Resident 6 got lost once. Maybe three months ago. The car left him some place else and did not know how to come [redacted], but the police was called already.

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The police brought him."

On , , at 12:40 PM, in reference to Resident 6, Staff B stated, "He is a , patient and when he finished his treatment, the place sent him on Uber and he asked the Uber driver to drop him off someplace else and got lost. We called the police and was brought to us when they found him."

Class III

0027 - Resident Care - Arrangement for Health Care - 58A-5.0182(3) FAC

Based on record review and interview, the facility failed to arrange health care services to one of seven sampled residents (Residents 2). Resident 2 was taken to the hospital with an hole in his abdomen, and fecal impaction.

Findings included:

Review of facility's admission/discharge log showed Resident #2 was admitted and discharged to the hospital on .

On , , , Staff C stated Resident #2 was at the hospital due to from the lower side of the body.

A review of the ambulance run record showed that the facility staff informed the paramedics that they had noticed two days earlier that the resident's had been dislodged. A review of the hospital record showed Resident #2, on examination found to have a hole in his abdomen where a should have been. The was , and the resident had a fecal impaction.

On , , at 8:45 AM, Staff B stated the resident was taken to the hospital and that the hospital might put a . She said that at admission, the resident did not have a and that the resident was eating normal food. A review of the health assessment showed that the resident needed a mechanical soft diet (mechanical soft is described as food that does not require a lot of chewing).

Review of the resident's health assessment dated documented a medical history of , injury, , , retention, and , unspecified abnormalities of gait and mobility, , . Assistance with most activities of daily living. According to the health assessment, the resident needed a mechanical soft diet, and the facility staff was unaware of this, so the

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resident had been receiving regular food. The record showed no documentation of notes related to any difficulties the resident had while living at the facility.

Class II

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

Based on record review and interview, the facility failed to provide health care services consistent with established and recognized standards for one of seven sampled residents (Resident 1), who became unresponsive and at the facility. Staff did not perform , , ( ) for a resident who did not have a ( ) in place.

Findings included:

Review of admission/discharge log showed, Resident #1's admission and discharged due to ; place discharged, to Funeral Home.

On , , at 7:50 AM, Staff C stated, "Resident #1 had issues; he went to the hospital for a procedure and when came , 5 days later, he passed here." Staff C stated that on the day of his , she was alone at the facility with all residents and the resident asked her to call 911, that he did not feel good and thought he was dying. Staff C stated she called 911, sat the resident comfortably and went to the kitchen to bring him water. When she went to see the resident, he was unresponsive. She stated she did not perform , and that the rescue arrived and told her he was , and took him."

Review of Staff C's personnel record did not show training. Further review showed valid documentation of training, which Staff C had completed on and which expired on .

Review of Resident 1's record showed that he was admitted to the facility on , and on . Last health assessment dated showed the resident was wheelchair and bed bound with a medical history and diagnoses of , in native , and of without pectoris. Assistance with most activities of daily living and total with ambulation. Progress notes for stated, "Today, the resident after he had dinner stated that he had lack of air and asked the staff to call 911; the staff followed the instructions that they gave her; when they arrived, they gave him first aid and transferred him to the hospital. After few hours, a Dade County police came to communicate that the resident had passed."

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Review of the Ambulance Run Record from Emergency Services showed that paramedics arrived 6 minutes after Staff C placed a call to 911. The record showed, "Upon arrival, patient found unresponsive. Pulseless with agonal . Patient was , and pupils were unresponsive. Patient was , ( ) on the monitor. protocol followed with no improvements. performed for 20 minutes on scene and then transported to hospital with no improvements."

Facility record review showed no documented policy or procedures regarding . On , at around 10:00 AM, observed the Administrator and Owner of the facility contact the previous owner regarding policies and procedures, who advised them to check the shed located outside on the backyard. Review of the facility's records for Residents # 1,2,3,4 and 5 showed that no resident had a in place.

In reference to procedures when a resident has a health emergency, Staff C stated, "I call 911 first, if they ask me, I give them ."

Class I

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(I)

Based on record review and interview, the facility failed to assess two of seven sampled residents (Resident 2 and 6) with risk for elopement or past elopement, and failed to implement precautions against further risk. Resident #2 away when returning from a medical , became lost, and was found by the police. The facility also failed to conduct a minimum of two resident elopement prevention and response drills per year.

Findings included:

1) On , at 12:40 PM, Staff B stated, "Resident 6 is a patient and when he finished his treatment, the place sent him on a private transportation and he asked the driver to drop him off someplace else and got lost. We called the police and was brought to us when they found him."

Review of Resident 6's record showed a health assessment dated stating the resident was not elopement risk. There was no documentation of a new assessment having been conducted after the resident away, and no record of safety precautions taken in case the resident again was found.

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2) Review of Resident 2's health assessment dated revealed that the resident was considered to be at elopement risk. A photo of the resident was not found in the record. Interviewed during the inspection on , Staff B was not aware that the resident was elopement risk.

Review of the facility's elopement policy, procedures and drills showed drills conducted , , . There was no documentation of two drills conducted in 2018, or drills conducted in 2019.

Class III

0076 - ( ) - 58A-5.0186 FAC

Based on record review and interview, the facility failed to provide ( ) to a resident who at the facility and did not have a ( ) in place. The facility failed to provide documention of a policy or procedure regarding . One of three sampled staff, who works alone at the facility, failed to demonstrate understanding of procedures, and there was no documentation that the staff had been trained regarding (Staff C).

Findings included:

Review of Resident #1's record showed that he was admitted on , and at the facility on . The resident's last health assessment dated showed that he was was wheelchair and bed bound with a medical history and diagnoses of , in native and of without pectoris. Resident #1'Assistance with most activities of daily living and total with ambulation. Progress notes for stated, "Today, the resident after he had dinner stated that he had lack of air and asked the staff to call 911 ; the staff followed the instructions that they gave her; when they arrived, they gave him first aid and transferred him to the hospital. After few hours, a Dade County police came to communicate that the resident had passed." Further review found no documentation of a for Resident #1.

Review of the records for the facility did not show policy and procedures for . On , at around 10:00 AM, when asked to provide the facilty's prolicies and procedures, the Administrator provided a blank resident choice form, used to determine whether residents acknowledged having a or wishing to be . A review of records for Residents #2,3,4,5 and 6 found no

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documentation of or resident choice forms. On , at around 10:00 AM, observed the Administrator and Owner of the facility contact the previous owner by telephone regarding policies and procedures, who advise them to check for an old policy predating the sale of the assisted living facility the shed, located outside in the backyard.

On , at 7:50 AM, Staff C stated, "Resident 1 had issues; he went to the hospital for a procedure and when came , 5 days later, he passed here." Staff C stated that on the day of his , she was alone at the facility with all residents and the resident asked her to call 911, that he did not feel good and thought he was dying. Staff C called 911, sat the resident comfortably and went to the kitchen to bring him water. When she went to see the resident, he was unresponsive. She stated she did not perform ; the rescue arrived and told her he was , and took him.

On , at 1:04 PM, Staff C stated In reference to which residents had , "No one here has it. I know because I speak with them." In reference to training, Staff C stated that she had all required training. In reference toprocedures when a resident has a health emergency, Staff C stated, "I call 911 first, if they ask me, I give them ."

Class I

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

Based on record review and interview, the facility failed to provide the required dietary needs to one of seven sampled residents (Resident 2), who needed a mechanical soft diet, and whom the facility was providing with regular food. The resident was hospitalized with an unexplained and hole in the and a fecal impaction.

Findings included:

Review of facility's admission/discharge log showed Resident 2's admission and discharged to the hospital on .

On , , Staff C stated Resident 2 was at the hospital due to from the lower side of the body.

Review of resident 2's record showed no progress notes. Staff B stated, "The resident was taken to the

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hospital and that hospital might put a [redacted]." The staff also stated that at admission, the resident did not have a [redacted] and neither the facility or his guardian were aware of any tube; that the resident was eating normal food. A review of the health assessment showed that the resident needed a mechanical soft diet. Mechanical soft is described as food that does not require a lot of chewing.

Hospital record review showed Resident #2 was hospitalized on [redacted], and on examination was found to have a hole in his abdomen where a [redacted] should have been. The [redacted] was [redacted], and the resident had a fecal impaction. According to the health assessment, the resident needed a mechanical soft diet. A review of the ambulance run record showed that the facility staff informed the emergency ambulance staff that they'd noticed two days earlier that the resident's [redacted] had been dislodged.

Resident #2's health assessment dated [redacted] documented a medical history of [redacted] injury, [redacted], retention, [redacted] and [redacted], unspecified abnormalities of gait and mobility, [redacted]. The resident needed assistance with most activities of daily living, was self-propelling in a wheelchair and independent with eating. Special diet: Mechanical soft diet. [redacted] or behavioral status: Moderately [redacted] cognition. Physical or sensory limitations: Decreased functional mobility.

On [redacted] at 8:23 AM, in reference to meals served to Resident 2, Staff C stated, "In the morning he used to eat coffee and toast; at lunch and dinner time, normal food."

On [redacted] at 8:45 AM, the Owner and Staff B arrived. Staff B stated, "I need to discharge Resident 2; they told me that he needs a tube."

In reference to procedures of resident admission to the facility, Staff B stated on [redacted] at 10:18 AM, "The administrator and I review the papers from the hospital or doctor." In reference on how they communicate any change on diet to the staff, "We tell the staff if they need special diet." In reference of any residents with mechanical soft food, Staff B stated, "No since we started in 2017." Observed the Administrator and Staff B review the health assessment for Resident 2 and realized that it stated, "Mechanical soft food."

Class III

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

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Based on record review and interview, the facility failed to file a surety bond with the agency in an amount equal to twice the average monthly aggregate income or personal funds due to residents, or expendable for their account, which are received by the facility.

Findings included:

Review of facility's records showed no documentation of surety bond for any resident's money received directly under the facility's name.

On at 10:00 AM, when Staff B was asked if the facility received resident payments directly under the facility's name, Staff B stated, "We receive direct payments for Residents 6, 3, 5, 7 and 2. I will take care of the bond as soon as possible."

Class III

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

Based on record review and interview, the facility failed to provide documentation of a signed contract for two of seven sampled residents (Residents #2 and #7). The facility also failed to provide a record for one of seven sampled residents (Resident #1)

Findings included:

1) Review of Residents #2 and 7's records showed admission date and all admission documents not signed by the residents or their legal representatives.

On , at 10:15 am, Staff B stated, "The guardian needs to pass by to sign all the paperwork."

2) Review of the facility's admission and discharge log showed Resident #1 admitted on , discharged on . The reason for discharge was listed as ' ', and the place discharged to as 'funeral home.'

Review of resident records showed that none existed for Resident #1.

On , at 7:50 AM, Staff C stated, "Resident 1 had issues; he went to the hospital for a procedure and when came , 5 days later, he passed here." Staff C stated that on the day

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of his , the resident asked her to call 911, that he did not feel good and thought he was dying.

On , at 7:58 AM, Staff B stated, "We keep old records at the office, not here, I would have to go and get it."

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 incident and a full report within 15 days to the agency including the results of the facility's investigation into the adverse incident for three of seven sampled residents (Residents #1, 2 and 6). Resident #1 became unresponsive and at the facility. Resident #2 was hospitalized for . Resident #6 away while going to the facility from a medical procedure and was found by the police.

Findings included:

1)
Review of facility's admission/discharge log showed Resident #2 was admitted and discharged to the hospital on .

On , Staff C stated that Resident #2 was at the hospital due to from the lower side of the body.

A review of the hospital record showed Resident #2, on examination, was found to have a hole in his abdomen where a should have been. The was , and the resident had a fecal impaction. A review of the ambulance run record showed that the facility 'staff informed them that they had noticed two days earlier that the resident's had been dislodged.

On , at 8:45 AM, Staff B stated the resident was taken to the hospital and that the hospital might put a . She said that at admission, the resident did not have a and neither the facility or his guardian, were aware of any tube; that the resident was eating normal food. A review of the health assessment showed that the resident needed a mechanical soft diet (mechanical soft is described as food that does not require a lot of chewing).

Review of the adverse incident report database showed no documentation of Resident #1's

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hospitalization.

2) Review of facility's admission/discharge log showed Resident #2 was admitted and discharged to the hospital on .

On , Staff C stated that Resident #2 was at the hospital due to from the lower side of the body.

Review of the adverse incident report database showed no documentation of Resident #2's being taken to a higher level of care for a condition which was not related to his known medical issues.

3)
On , at 1:04 PM, Staff C stated, "Resident #6 got lost once. Maybe three months ago. The car left him some place else and did not know how to come , but the police was called already. The police brought him."

Review of Resident #6's record showed no documentation regarding the resident having been lost and brought home by the police.

Review of the adverse incident report database showed no documentation of Resident #6's incidence of being missing.

On , at 12:40 PM, Staff B stated, "Resident #6 is a patient and when he finished his treatment, the place sent him on Uber and he asked the Uber driver to drop him off someplace else and got lost. We called the police and he was brought to us when they found him."

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation and interview, the facility failed to provide documentation of the amount of fuel that needed to be stored onsite to ensure that the room temperature could be maintained at or below 81 degrees for 48 hours in the event of the loss of primary electrical power.

Findings included:

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On [redacted] at 7:30 AM, observed inside a shed located on the backyard of the facility, a portable generator and two five gallon fuel containers.

On [redacted] at 11:45 AM, the Owner stated, "I need to find the manual, I will work on this right away. I also will go to the fire department to find out if they allow gasoline to be stored in the facility."

Class III