STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966909	**02/27/2019**
NAME OF PROVIDER OR SUPPLIER **LUCY'S HOME CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **2005 SW 97 AVENUE** **MIAMI, FL 33165**	

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

0000 - Initial Comments

A Standard Biennial Survey was conducted on . . . . . , . . to . . . . . , . . Lucy's Home Care, Inc. with a Limited Mental Health component license, had the following deficiencies identified at the time of survey:

0004 - Licensure - Requirements - 58A-5.016 FAC

Based on record review and interview, the facility failed to provide proof of a current fire inspection and a current health inspection.

Findings included:

Review of the facility's inspection reports showed the last satisfactory health inspection dated . . . . . According to the administrator, they called the department requesting an inspection, but they had not received it yet.

Review of the facility's inspection reports showed a failed inspection conducted . On am at about 7:30 am, the Administrator state thehadde passed the re-inspection but did not know what happened to the report.

Class III

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

Based on observation, record review and interview the facility failed to ensure that two of five sampled residents met the admission criteria (Residents 1 and 2).

Findings included:

On , , at 7:00 AM, Staff B stated that there were 5 residents, none of them on hospice and none of them with . . administration.

On . . . . . , ... at 7:00 AM, observed Residents 1 and 2 in their room. Resident 1 was sitting on a portable potty while Resident 2 was in bed. The residents never left the between 7:00 AM and 2:30 PM.

On , , at 1:45 PM, observed Staff B and the administrator trying to get Residents 1 and

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2 up to demonstrate s that they could walk with assistance, but neither resident could stand nor make steps. The Administrator stated that both residents had 's and sometimes they could walk and at other times could not.

Review of Resident 1's record showed a health assessment dated with a diagnoses of and . The resident needed precautions, and assistance with all activities of daily living except for supervision with eating.

Review of Resident 2's record showed a health assessment dated with a diagnoses of and . Thresidentnt needed precautions, and assistance with all activities of daily living except for supervision with eating.

On , at 6:11 AM, observed the Administrator washing her , taking medication record and medications for Resident 2 from medication cabinet, putting new gloves on and taking every thing to Resident 2's room. Resident 2 had jello on the side to help her swallow the medications. Observed that administrator touched the first medication with gloves rather than putting the pill into the cup. Administrator encouraged the resident to lift the cup to her ; however, the resident was weak and was not able to lift her arm without assistance. The Administrator stated that she was aware that the resident had to be in hospice.

On , at 4:42 PM during a phone interview with both residents' doctor, he stated, "In the health assessment, it mentions ambulation requires assistance, bathing and assistance, eating supervision." The doctor was asked if he had witnessed the resident physically walk ; the doctor stated that he did not recall the specific moment and was simply going off on what was on the member's health assessment in front of him. The doctor stated that there was no way for him to remember because he saw close to 2,000 patients on a monthly basis. The doctor further stated, "The usual way is since I see the patients on a monthly basis, if they're sleeping because they just finished eating, I won't wake them up unless there's a significant change; however, when it's an initial assessment I do have them do all the things on the health assessment."

Class III

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

Based on observation and interview, the facility failed to honotwoeo of six sampled residents residents' right to be treated with dignitandnd respect, free of . by restraining Resident 2's was barred

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from being able to get up from bed by blocking it with a wheel chair. The facility failed to provide Resident 1's privacy in the shared room. The facility also failed to give Resident 5 access to the closet and the refrigerator inside his bedroom.

Findings included:

On , , at 7:00 AM, observed a wheel chair located against Resident 2's bed while the resident was still on bed sleeping. According to Staff B, they did it to avoid the resident from falling from the bed at night. Observed Resident 1 seating on a portable potty while eating breakfast and then lunch in front of roommate, Resident 2, with no partition to provide privacy to the resident.

On , , at 7:15 AM, observed generator and portable air conditioners inside Resident 5's room closet.

On , , at 7:15 AM, Staff B stated that he did not leave the portable air conditioners or generator outside because it gets stolen.

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 correct procedure outlined by the state when assisting with self-administration of medications for one of five sampled residents (Resident 2).

Findings included:

On , , at 6:11 AM, observed the Administrator washing , taking medication record and medications for Resident 2 from medication cabinet, putting new gloves and taking every thing to Resident 2's room. Resident 2 had jello on the side to help her swallow the medications. Observed that administrator touched the first medication with gloves rather than popping the pill into the cup. Administrator encouraged resident to lift the cup to her ; however, resident was weak and was not able to lift her arm without assistance. Administrator stated that she was aware that the resident had to be in hospice but would administer the medication.

Class III

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

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Based on observation and interview, the facility failed to keep out of the resident's rich, over the counter medications. The facility failed to dispose properly medications that the residents were not longer prescribed. The medications may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness.

Findings included:

On [redacted] at 7:30 AM during the tour, observed over the counter Nighttime [redacted] and Flue Relief bottle on top of the living room table. Staff B stated, "This belongs to me, I will put it away."

Also during the tour, observed closet doors locked, Staff B stated that he did not have the key, that the administrator would bring them. When the administrator arrived at 8:00 AM and opened the doors, observed the following prescribed and over the counter medications: [redacted] rub, [redacted] cream, [redacted] cream 12%, [redacted] cream, [redacted], 1 inhaler, [redacted] 160 mg and prescribed medication for Resident 2, [redacted] dated [redacted].

On [redacted] at 8:15 AM, the Administrator stated, "Those are medications that they do no need anymore."

Class III

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

Based on record review and interview, the facility failed to maintain an accurate MedicatioObservationon Record (MOR) for one of five sampled residents (Resident 2). The facility initialed medications twice per day that were only given once per day.

Findings included:

Review of the MOR for Resident 2 showed medications [redacted] and Multi [redacted] tablets initialed twice a day when medication containers showed quantity of 30 for the month.

On [redacted] at 9:55 AM, the pharmacy was contacted and the pharmacist who verified that [redacted] is used for [redacted] 24 MCG Capsules taken once a day orally and the multi [redacted] tablets are also once a day. Explained that MOR shows 7 AM and 7 PM. The pharmacist admitted that it was a pharmacy error where the pharmacy tech did not remove the 7 PM time slot, then stated that they are

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not refilling it twice a month. Medication card should only have 30 pills and that the only pills remaining should be from the 23rd through the 28th. He stated that he would correct the MOR as soon as possible and have their delivery driver come to the pharmacy to pick up the MOR and deliver it to the facility the same day.

Class III

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

Based on observation and interview, the facility failed to maintain the furniture clean and in good condition.

Findings included:

On during the tour of the facility, observed a recliner located inside that looked faded, dirty and broken.

On at 6:30 AM, Resident 5 stated, "What am I going to do? I like to be thbedroomom all day; I do not go out."

Class III

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

Based on record review and interview, the facility failed to maintain records of previous residents or some documents of current residents at the facility for at least two years. The facility failed to verify that all the information on the health assessment of one of five sampled residents was completed, (Resident 1).

Findings included:

Review of Resident 1's record showed a health assessment dated missing the resident's and . The Administrator stated that she was going to review the record and ask the doctor to complete it.

On while reviewing resident records, the administrator was requested to provide old records and previous health assessments from current residents. At 10:40 AM, the Administrator stated, "I do not keep any records here at the facility, I know that I have to keep them for 5 years but I do not

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have them here. I only bring them when another State agency asks for them; no one has ever asked for old records. Once we get a new health assessment, I take the old one from the record."

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation and interview, the facility failed to maintain the alternate power source, generator, outside 10 away from the facility. The facility failed to implement the plan as the approved plan and application was not sent for review to the agency.

Findings included:

On , at 7:15 AM, observed generator and portable air conditioners inside Resident 5's room closet.

On , at 7:15 AM, Staff B stated that he does not leave the portable air conditioners or generator outside because it gets stolen.

Review of the facility on the facility founder showed no information regarding the alternate power plan been submitted. During the exit conference, the administrator acknowledged that the plan was not submitted to the agency.

Class III