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	AL11969261	**03/12/2019**
NAME OF PROVIDER OR SUPPLIER **FIVE STAR ASSISTED LIVING FACILITY INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **5384 NW 4 ST** **MIAMI, FL 33126**	

SUMMARY STATEMENT OF DEFICIENCIES
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Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review, and interview, the facility failed to maintain an updated employee roster within the background screening clearinghouse database for two out of eight (Staff G and H) sampled staff.

Findings included:

Record review of background screening clearinghouse database showed that Staff G hired on and Staff H hired on were not listed.

Interview conducted on at 1:30 PM, Administrator confirmed that Staff G and H were not listed in the clearinghouse database.

Unclassified

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

Based on record review and interview, the facility failed to ensure that any person whose responsibilities required to provide personal care or services directly to residents or had access to residents, their personal funds or living areas had an eligible Level II background screening.

Findings included:

A review of the background screening database showed the owner's brother (Staff F) had an ineligible level II background screening dated and Staff I did not have an eligible level II background screening. Review of law enforcement and clerk of court public databases revealed Staff F had three different alias (names), had a conviction for battery and felony convictions for intent to distribute or sell , credit card fraud and possession of instruments to simulate drivers' licenses.

On at 1:01 PM, the Administrator stated Staff F was the owner's brother. She stated he brought the facility's supplies and worked on the facility's maintenance.

On at 2:17 PM, Staff F stated that he was the owner's brother and helped the owner with the facility's maintenance such as fixing bathrooms, painting the facility, landscaping and buying groceries for the facility. Staff F also admitted that he transported one resident to the bank at her request. In addition, he was not aware that he required to have a level II background screening. Staff F refused to provide any personal information such as his date of birth because he was not considered a facility staff .

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Record review found Residents #1, 2, and 3, who were bed bound and needed total assistance with ambulation, bathing, and grooming had between , and 13, 2019.

Resident #1 was diagnosed with , , , ( ), , , , , ( ), , Behavior, , , High . Hospital records showed that the resident the resident had low , and two , (one and one on his). Further record review showed that the resident was also paraplegic, bed bound, and had severe , .

A review of Resident #2's record showed he was was diagnosed with 's , Gait disturbance, , , and . Progress notes on stated the resident was weak and needed assistance with his toileting. On , the resident refused to eat and was transferred to the hospital by non-emergency ambulance. Hospital record review indicated that his admitting diagnoses were acute hypoxic , , failure due to , , severe , , hypernatremia (high concentration of).

Resident #3 was diagnosed with , , Memory Loss, Hypertensive , , , globe, and , . Progress notes dated showed there were clots in his and , during . The resident was sent to hospital. Hospital records showed that he had exudative , on both , and . The resident was completely disoriented on admission. The resident later then passed for causes related to .

A review of Resident # 4's record admitted on , showed he was diagnosed with , , , , , , and .

A review of Resident #5's record showed she was admitted to the facility on diagnosed with , , , , , , and Deficiency.

A review of Resident # 6 file showed she was admitted and diagnosed with , (Multiple Episodes Acute Severe).

A review of Resident # 7's record showed he was admitted and diagnosed with Kyphosis, Turner's , , , , , Function .

A review of Resident # 8's record showed he was admitted and diagnosed with 's

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, , Gait Disturbance.

A review of Resident # 9's record showed he was admitted on and diagnosed with 's , , Unsteady Gait, , Recurrent ( ), and , ( ).

A review of Resident #10's record showed he was admitted on and diagnosed with , Left Hydrocele, Gronulomatous , of , , , , , and , .

A review of Resident #11's record showed he was admitted on and diagnosed with , , ( ), , ( ), , - functional decline, Peripheal , and .

A review of Resident # 12's record showed she was admitted on and diagnosed with Major , , (OA), , , , , , ( ).

A review of Resident # 13's record showed he was admitted on and diagnosed with Essential , w/ ( ), , ( ), , history of , , , Type II (non dependent), , Major , , , , .

On at 2:43 PM, the Owner stated Staff F was her brother but he was not a facility's staff. She said her brother assisted her with the facility's maintenance duties and he was not required to have a level II background screening. She was not aware that her brother assisted residents with transportation at any time.

Class II

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0000 - Initial Comments

A Complaint survey CCR # 2019000892 was conducted on [redacted] & [redacted]. Five Star Assisted Living Facility Inc. with Limited Mental Health service component had deficiencies identified at the time of the survey:

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

Based on observation, record review, and interview the facility failed to arrange access to health care for three out of 14 (Resident #1, 2 and 3) sampled residents. Residents # 1, 2, and 3 after not receiving adequate healthcare while living at the assisted living facility. Resident # 1 also had an and did not receive any care. Resident # 2 had and severe. Resident #3 had and acute.

Findings included:

Facility and hospital record review revealed that Residents # 1, 2, and 3 became ill and were admitted to the hospital between and 13th, 2019. All three residents that month, from conditions that had been longstanding. There was no documentation that they had been receiving medical care:

1) A review of the admission/discharge log and the resident record showed that Resident #1 was admitted to the facility on. An undated health assessment showed that he was diagnosed with, (), (-),), Behavior, , High .

A review of progress notes from showed that the resident had a low and staff had called 911 to have the resident taken to the hospital. Hospital records showed that the resident became unresponsive in the ambulance and was taken to the hospital where it was discovered that had had two (one and one on his). Further review of the hospital record showed that the resident was also paraplegic and bed bound, and had severe .

Review of the fire-rescue reported from showed that the resident received Narcan due to a .

Further review of the health assessment and hospital records also showed that the resident had and was not able to swallow medication capsules or tablets. There was no documentation at the facility that the resident had .

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Review of the resident's primary physician records showed that he was only seen twice in the year before he : on and . There was no documentation that resident was receiving care treatment for the two , prior to the hospital admission . Review of clinic records showed the resident had last been seen on and .

On at 3:30 PM, Resident's #1 daughter stated that she and her sister had purchased a pill crusher and gave it to the facility to use, but staff did not use it. The daughter also stated that she witnessed the staff give the resident his medication without crushing the pills.

On at 1:00 PM, the Administrator stated that the resident was able to swallow his medication regularly and did not have any , .

2) A review of the admission/discharge log and the resident record showed that Resident Resident #2 was admitted to the facility on . Health Assessment completed on states that he was diagnosed with 's , Gait disturbance, , and .

Progress notes on stated the resident was weak and needed assistance with his toileting. On , the resident refused to eat and was transferred to the hospital by non-emergency ambulance. There was no documentation regarding medical care for the resident prior to the ambulance picking him up.

Hospital record review indicated that his admitting diagnoses were acute hypoxic , failure due to , severe , hypernatremia (high concentration of). The resident was then admitted to ( ) where he , in the morning of .

On at 11:41 PM, the resident's son stated "He said his were shaking; he had a bad and refused to eat. The facility contacted rescue and he was transferred to the hospital. That night he had a in the hospital and , ."

On at 11:59 AM, the Administrator stated that staff her told that someone from the resident's clinic came and told them that he continued to deteriorate and they needed to call rescue. The resident had and was weak. She stated "He refused to eat. We contacted rescue. He was transferred to hospital. I contacted his clinic."

Review of clinic record showed that the resident had been seen at the facility on , when he was identified as homebound, with a diagnosis of , and generalized , and he was

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referred to the hospital for close follow up. There was no documentation that the resident was referred to the hospital by either the clinic or the facility staff.

3) A review of the admission/discharge log and the resident record showed that Resident #3 was admitted to the facility on . A health assessment completed on showed he was diagnosed with , Memory Loss, Hypertensive , globe, and (a condition related to a). Progress notes dated showed there were clots in his and during . The resident was sent to hospital.

A review of hospital record from the admission showed that he had exudative on both and a past history of . The resident was completely disoriented on admission to the hospital. The resident eleven days later due to complications of .

Further review of the facility record showed no documentation regarding residents' history of and . There was no documentation that the resident had been receiving medical attention prior to his .

Class I

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

Based on observation, record review and interview, the facility failed to follow proper procedures during assistance with self-administration of medication for one out of ten (Resident #10) sampled residents. The facility failed to maintain accurate Medication Observation Records (MOR) for three out of ten (Resident #7, 8 & 9) sampled residents.

Finding include:

On at 12:53 PM, observed Staff B wore gloves, and popped two medications from the medication pack onto her gloves and handed them to Resident # 10 with a cup of water.

Medication Observation Record review showed:

-Resident # 7 was prescribed Olapatadine 0.2% . MOR was initialed with an "M" indicating the resident was receiving the medication. Medication reconciliation showed the medication

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was not in the facility.

-Resident # 8 was prescribed , 20 mg Capsules with an instruction to take two capsules together daily. MOR showed that the resident is taking one capsule at 7AM and one capsule at 7PM. The MOR is initialed for 7AM, but not for 7PM. Record review also shows that the MOR is missing the dosage amount for medication Montekalust 10 mg Tab.

-Resident # 9's MOR was initialed with a letter 'V' from through . Medication reconciliation showed that the resident did not take the following medications: , 5mg Tablet, 325mg Tablet, 500mg Tablet, and , HBR 20mg Tablet.

Interview conducted on at 1:10 PM, Staff B stated, "I did not know that I can not touch resident's medications with my . I've always done it that way." She said Resident #7's daughter was going to bring the medication to the facility. She gave Resident #8's two capsules of , 20 mg once a day, but the resident decided to take one capsule in the morning and kept the second capsule in his pocket and took it at nighttime and she forgot to initial the 7 PM slot. She added Resident #9 had gone to her house during the beginning days of and the initial 'V' stands for 'visiting'. She also stated that some of Resident's #9 medications arrived after the resident had left and the family had the medications at home.

Class III

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

Based on observation, record review and interview, the facility failed to refill a medication in a timely manner.

Findings Include:

Medication Observation Record review showed Olopatadine 0.2 % was marked as received at 7:00 AM daily.
Medication Reconciliation showed that Olopatadine 0.2 % was not in the facility.

On at 10:10 AM, Staff B stated that the resident's daughter was going to bring the medication to the facility.

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Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on record review and interview, the facility failed to have qualified staff to meet the scheduled and unscheduled needs of the residents for 14 out of 14 sampled residents. The facility failed to maintain a written work schedule that reflected its 24-hour staffing pattern for a given time period.

Findings included:

On [redacted] at 8:00 AM and on [redacted] at 8:30 AM, observed Staff C caring for and providing personal services to ten residents and Staff B was working in the kitchen.

A review of assisted living licensure requirements showed the facility needed to maintain 212 minimum staff hours per week for 14 residents between the months of [redacted] through [redacted].

Record review found that Residents #1,2 and 3, who were bed bound and needed total assistance with ambulation, bathing, and grooming had [redacted] between [redacted] and 13, 2019. Resident #1 was diagnosed with [redacted] ([redacted]), [redacted] ([redacted]-[redacted]), [redacted] Behavior, [redacted], High [redacted]. Hospital records showed that the resident the resident had low [redacted], and two [redacted] (one [redacted] and one [redacted] on his [redacted]). He was also paraplegic (bed bound) and had severe [redacted]. Resident #2 was diagnosed with [redacted] 's [redacted], Gait disturbance, [redacted], and [redacted]. Progress notes on [redacted] stated the resident was weak and needed assistance with his toileting. On [redacted], the resident refused to eat and was transferred to the hospital by non-emergency ambulance. Hospital record review indicated that his admitting diagnoses were acute hypoxic [redacted] failure due to [redacted], severe [redacted], hypernatremia (high concentration of [redacted]). Resident #3 was diagnosed with [redacted], Memory Loss, Hypertensive [redacted], globe, and [redacted]. Progress notes dated [redacted] showed there were [redacted] clots in his [redacted] and [redacted] during [redacted]. The resident was sent to hospital. Hospital records showed that he had exudative [redacted] on both [redacted] and a past history of [redacted]. The resident was completely disoriented on admission. The resident later then [redacted] under hospice care related to [redacted].

A review of Resident #2's record showed he was diagnosed with [redacted] 's [redacted], Gait disturbance,

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, and . Progress notes on stated the resident was weak and needed assistance with his toileting. On , the resident refused to eat and was transferred to the hospital by non-emergency ambulance.

Hospital record review indicated that Resident #2's admitting diagnoses were acute hypoxic , failure due to , severe , hypernatremia (high concentration of). Resident #3 was diagnosed with , Memory Loss, Hypertensive , globe, and . Progress notes dated showed there were clots in his and , during . The resident was sent to hospital. Hospital records showed that he had exudative on both and . The resident was completely disoriented on admission. The resident for causes related to .

A review of resident records showed that all residents required assistance with the activities of daily living.

A review of Resident # 4's record admitted on , showed he was diagnosed with , , , , , , and , .

A review of Resident #5's record showed she was admitted to the facility on diagnosed with , , , , , , and Deficiency.

A review of Resident # 6 file showed she was admitted and diagnosed with , (Multiple Episodes Acute Severe).

A review of Resident # 7's record showed he was admitted and diagnosed with Kyphosis, Turner's , , , , Function .

A review of Resident # 8's record showed he was admitted and diagnosed with 's , , , Gait Disturbance.

A review of Resident # 9's record showed he was admitted on and diagnosed with 's , , , Unsteady Gait, , Recurrent , ( ), and ( ).

A review of Resident #10's record showed he was admitted on and diagnosed with , Left Hydrocele, Gronulomatous , , , , of , , , , , and , , .

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A review of Resident #11's record showed he was admitted on [redacted] and diagnosed with [redacted], [redacted] ( ), [redacted] ( ), [redacted] - functional decline, Peripheal [redacted], and [redacted].

A review of Resident # 12's record showed she was admitted on [redacted] and diagnosed with Major [redacted] (OA), [redacted] ( ).

A review of Resident # 13's record showed he was admitted on [redacted] and diagnosed with Essential [redacted] w/ [redacted] ( ), [redacted] ( ), [redacted], history of [redacted] Type II (non [redacted] dependent), [redacted], Major [redacted].

Facility record review showed there was no work schedule available for review for the months of [redacted] and [redacted].

On [redacted] at 10:05 AM, Staff B stated that she and Staff C were currently working at the facility for 24 hours 6 days a week because the facility did not have another staff member to release them of duty. Staff B also explained that she alternated weekend days with Staff C. Additionally, Staff B stated that her duties consisted of cooking breakfast, lunch, and dinner. Meanwhile, staff C was in charge of cleaning and assisting residents with activities of daily living. Observation showed that Staff C alone was providing care to the 10 residents.

On on [redacted] at 9:20 AM, the Administrator stated she did not keep any documentation of the staff that worked at the facility. The Administrator also stated that the owner was in charge of the payroll and explained that she would only give the owner a list of the names of the staff that worked in the facility each week. The Administrator stated that Staff G was on vacation during the month of [redacted] and Staff H resigned in the same month ( ); however, she was unable to recall which employee worked at the facility during that time.

Interview conducted on [redacted] at 9:29 AM, the Owner explained that she currently had a second job and managed the finances for the facility. The Owner stated that she did not keep a record of staff paychecks or pay history because she pays staff with checks or cash, depending on the day. Owner also stated that she relied on the administrator and/or staff to tell her how many days they had worked.

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Class I

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

Based on observation and interview, the facility failed to have menu dated at least one week in advance.

Findings Include:

Observation on . . . . . at 10:10 AM showed the facility menu posted in the dining area was not dated.

Interview conducted on . . . . . at 12:10 PM, Administrator confirmed that the menu posted was not dated.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on record review, and interview, the facility failed to ensure the staff records had documentation of the required Level 2 background screening results for one out of eight (Staff C) sampled staff.

Findings included:

Review of Staff C's record showed no documentation of the level 2 background screening.

A review of the Agency's background screening database showed Staff C had an eligibility status dated

.

Interview conducted on at 1:10 PM, Administrator confirmed that Staff C's record did not have documentation of the level 2 background screening.

Class III

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

Based on interview and record review, the facility failed to use an adequate health assessment form 1823 for one out of 10 (Resident #5) sampled residents. The facility also failed to verify all information was completed on a health assessment for one out of ten (Resident # 5) sampled residents.

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Findings included:

Review of Resident # 5's record showed that the first health assessment was completed and the form did not have a signature nor a date of examination. The resident's last health assessment was completed on an outdated form dated and sections Physical or Sensory Limitations and or Behavioral Status were left blank.

On at 1:12 PM, when asked, Administrator stated she did not have an updated form since she is not the one responsible to complete the form.

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 file an adverse incident report within one business day and fifteen days for three out of fourteen (Resident #1, 2 and 3) sampled residents.

Findings included:

Resident #1 was admitted to the facility on . An undated health assessment showed that he was diagnosed with , , , ( ), , Behavior, , , High . Progress notes from stated that the resident was with a low , and staff had called 911 to have the resident taken to the hospital. Hospital records showed that the resident became responsive in the ambulance and was taken to the hospital where it was discovered that the resident had low , and two , (one and one on his). He was also paraplegic (bed bound) and had severe . Fire rescue reported that the resident received Narcan due to a . Records also showed that he had , , and was not able to swallow medication capsules or tablets. There was no documentation at the facility that the resident had , , . Resident #1 was discharged from the hospital on and 10 days after. Review of the resident's primary physician records showed that he was only seen twice on and . There is no documentation that resident was receiving care treatment for the two , prior to the hospital admission .

Resident #2 was admitted to the facility on . Health Assessment completed on

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states that he was diagnosed with 's , Gait disturbance, , and . Progress notes on stated the resident was weak and needed assistance with his toileting. On , the resident refused to eat and was transferred to the hospital. Hospital record review indicated that his admitting diagnoses were acute hypoxic , failure due to , severe , hypernatremia (high concentration of). The resident was then admitted to ( ) where he , in the morning of . There was no documentation regarding medical care for the resident prior to the admission.

Resident #3 was admitted to the facility on . Health Assessment completed on showed he was diagnosed with , , Memory Loss, Hypertensive , globe, and . Progress notes dated showed there were clots in his and during . The resident was sent to hospital. Hospital records showed that he had exudative on both and a past history of . The resident was completely disoriented on admission. The resident later then , under hospice care related to . The resident was transferred to the hospital's hospice on where he . Facility failed to provide any documentation regarding residents' history of and . There was no documentation in the facility that the resident had been receiving medical attention prior to his .

On at 1:10 PM, Administrator stated, "We did not report it."

Class III