STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953342	R 04/24/2019
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 revisit to a biennial survey was conducted at Professional Home Care III, Inc. on and concluded on . Deficiencies were 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 provide and and services to two of 14 sampled residents (Residents #6 and #14). The facility failed to have interventionns in placed after Resident #6 was reported missing to law enforcment and later found at the hospital twice within the last six months. Also, the facility failed to have precautions in place after Resident #14 at the facility on a wet floor that resulted in being transferred to the hospital with a left .

Findings included:

1) Review of Resident #6's record showed on the resident was reported as a lost resident. Resident was last seen at the facility on at 6:00 pm. On , he was located at the hospital. Record review showed on Resident #6 was missing from the facility, last seen at 4:25 PM. On , Resident #6 was located at the hospital.

Hospital records from documented Resident was in the hospital for multiple days. The records documented "the patient presented to the emergency room by fire rescue, had been complaint of lower extremity , . The patient with history of and was awake. the patient, after drinking , became weak in his and he to the ground and he called fire rescue."

Hospital records on /19 revealed "reported , exacerbated by use... Right forehead , . Patient admits has been drinking . The patient presents with and . The onset was just prior to arrival. The character of symptoms is and combative. Baseline status: , decreased responsiveness. Risk factors consist of intoxication."

In the incident report submitted to the Agency for Resident #6, the facility stated on at 1:08 PM, "We will keep a closer attention to him and make sure all the door are always secure.

Regarding the second incident when Resident #6 left the facility on . The facility stated on at 8:55 AM, "We have a policy of sign out of the ALF and the book is located next to the front

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door. He didn't sign in the book. A corrective action will be to have all the door secure and making sure they remain closed all the time. We will talk to him to explain the consequences of leaving the ALF and being on the street without medicine and food."

The facility's elopement policy revealed staff would be trained within 6 month of their hire date instead of having the required training within 30 days. The facility defines elopement as an occurrence in which a resident leaves the facility without following facility policy and procedures. Elopement is defined when a resident leaves the facility's property beyond the perimeter or the parking lot or further, he/she is missing for more than 24 hours, he/she leaves without the facility's knowledge because he/she has not verbally information the facility staff of their plans for returning to the facility.

On at 2:40 PM, Staff B stated on Resident #6 went to visit a friend and the friend did not bring him . Staff B stated Resident #6 did not recall the facility address or telephone number. Staff B stated on , the cable company staff left a door open, and Resident #6 walked out of the facility through the open door. Staff B stated the staff monitor Resident #6 but the Resident was allowed to leave the facility because he did not have 's.

In an interview the Resident #6's Caseworker stated on at 12:51 PM that she was aware of Resident #6 elopements on and . She said the facility staff had notified her each time. The Caseworker stated Resident #6 is not competent to travel independently outside the facility grounds. She stated he should be supervised at all times because he did not remember how to return to the facility and he did not remember facility address. She stated each time he eloped he did not remember to eat or drink, became sick, and sent to the hospital.

The facility was unable to provide any documentation that a plan was put in place to prevent Resident #6 from leaving the facility without supervision after Resident #6 was reported missing twice and being hospitalized after each incident. The facility also did not have an elopement assessment completed for Resident #6. On at 2:50 PM interview with Staff A and B revealed, "We do not have implemented any care plan to prevent Resident #6 from leaving the facility. They confirmed a assessment had not been completed for Resident #6.

Resident #6's health assessment dated had a history of ( ), Severe , ( ), Carotid , Neurosyphillis, , ( ), in both , and Precautions. Resident #6 required assistance with self-administration of medications.

2) On at 9:45 AM, observed Resident #14 lying in bed with a next to the bed.

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Review of Resident #14's record showed on the resident . Record review revealed a staff member was mopping the floor and Resident #14 walked on the wet floor and . On , Resident was sent to the hospital and found to have had a on the left .

Hospital records revealed Resident #14's chief complaint was left ankle and and after the resident was transferred by emergency medical services on (days after the). Staff at the facility noticed and discoloration to left and ankle following. report documented minimally displaced of the left . Minimally displaced of the left . Minimally displaced of the medial, aspect of the left cuboid bone. Surrounding soft tissue .

On at 2:50 PM, Staff B stated a staff member was mopping the floor near the dining room. The staff member told Resident #14 not to walk on the floor, but he did not listen and walked across the floor to go outdoors to smoke. Staff B stated the doctor was notified and ordered x-ray and no injury showed on the . Staff B stated a few days later Resident #14 left was and doctor was notified again. The doctor gave order to send Resident #14 to hospital. Resident #14 was admitted to the hospital on to . Staff B stated the hospital informed the facility Resident #14 had a to left .

The facility had not put in a place a plan of care/action for Resident #14 to prevent . Interview with Staff A and B revealed, "We do not have implemented any care plan to prevent Resident #14 from falling.

Resident #14's heath assessment dated had a history of , with , Delay and Major , .

Class II

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

Based on record review and interview, the facility failed to provide service for one of three sampled residents (Resident #9) that was ill for two days, and he did not receive health care from the facility, which caused his .

Findings included:

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Record review revealed Resident #9 was discharged on , he , .

The ambulance company's report dated documented a picked up request at 4:18 pm for Resident #9 stated, " and at times. Abdomen looks and has not eaten for 2 days. Advice caller to call 911 if patient worsen."

Further review of the report found at 4:37 pm, "Crew called, Nurses came out and believe patient coded and called rescue. Nurse advised crew patient is unresponsive, called dispatch then made patient contact, not responsive to rub, no , crew started , . Nurses facility did not start , before arrival. Fire Department called patient . Police department arrived on scene after."

Fire rescue report dated stated, "On arrival at ALF facility found patient on the floor with no signs of life. Patient was to touch with and the initial rhythm was , on the leads. Patient was pronounced at 4:48 pm."

On at 2:17 PM, Resident #9's doctor reported during an interview that the facility staff called him after the resident had already passed. He was not informed that Resident #9 had , or refused to eat. The doctor said he did not expect to be called for little issues, but he expected to be informed by the facility if a resident had not eaten for two days.

Interview on at 12:54 pm Resident #9's Caseworker stated that on she received a telephone call from the facility staff stating Resident #9 had , . She stated she did not receive a call prior to that explaining he did not eat and had , . She stated she was not aware Resident #9 had not eaten for 2 days.

Resident #9's health assessment dated revealed the following diagnoses , , , , , Overactive , and , , ( ). precautions due to , and use a cane. Memory loss and supervision for daily living activities (ADLs).

Review of the observation log dated found, "Resident #9 did not want to have lunch and complained of , in his . The owner was informed and she decided to send him to the hospital. The staff went to inform him that the ambulance had already arrived but he fainted. While being applied , the rescue was called who continued giving but he ."

The facility's / Advance Directives Policy stated, "The facility can call 911 at any time

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to provide family/caregivers with up and support for the resident. The facility may call 911 to control and to make sure the resident is comfortable. Emergency medical services are part of the community are able to provide appropriate care as needed in may capacities. A " " only means that in even of or that will not be initiated."

Interview on at 11:30 am Staff H stated, "I was serving dinner. Resident #9 was sitting on the eating area as usual and he stated that he did not want to eat. I asked him if he would like to eat something else; however, he responded no. I asked him if he was feeling sick, and he responded, yes. He told me that he had . I did not call Resident #9's Physician; I called my boss (Staff G), and she told me to call the ambulance. While I was calling the ambulance, Staff F accompanied Resident #9 to his room to assist him with . The ambulance arrived earlier than we expected, they usually takes 20 minutes, but in this occasion, they took less time. They arrived fast, I had not an exactly time, but they arrived soon and started . Then, they told me to call 911, and I called and the rescue arrived immediately, too. The Rescue took over, however Resident #9 .

Interview on at 3:23 pm Staff C stated, "We had dinner from 4:00 pm - 5:00 pm. Resident #9 was sitting on the dining area, but he had , and he refused to eat; I saw that myself. We asked him, if he wanted to go to the hospital, and he responded, "Yes." We asked first, if he would like to eat something else, but he did not want to eat. Staff H called the boss, and Staff G stated to call the ambulance for him. Resident #9 walked to his room to change his clothes, but he felt on bed. Staff F realized that something was going wrong on Resident #9. Staff F told me that she saw him on bed because she left the door between open to observe him.

Interview on at 3:45 pm Staff F stated, "I was working on in the facility. Resident #9 was in the dining area, and he stated that he was not hungry. Resident #9 had his on his , and Staff H called the boss, while I walked with Resident #9 to his room to change his clothes. I passed him an underwear and pajamas, and I stood up in front of the door. I kept looking, at him. Then, I saw Resident #9 sitting on his bed putting the clothes on. Resident #9 suddenly laid his body on the bed with his out, and the rest of his body on the bed. I walked closed to him to see what was going on, and I saw his , which were opened, I touch his , and I got his , and he was breathing, I did not have to do , he was alive. He was heavy to fix straight on bed by myself, and I could not fix him into the bed completely. I intended to step out from the room to advise Staff H of his rapidly changed on health condition; however, Staff H was also walking toward us. I let her know that he laid on his bed, and she started to call the Rescue from her cellular. Staff H was with me, she made all the calls from her cell next to me. Then, in that moment, we saw the ambulance transportation arriving, we could see it from Resident #9's room because it located next to the sitting area where there is a big window. We saw the transportation, they arrived very soon. Resident #9 rushed to open the front door for the ambulance

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employees, and guided them to Resident #9's room. I never left Resident #9 alone, and I never left the room. I did not execute , because I took his , , and he was alive, and his were opened, too. He was not verbally responding, but he was still alive. As soon, the ambulance employee arrived to the facility, they started , and the Rescue arrived immediately and they took over the , they took us out from the room, and did their job. However, Resident #9 .

Interview on at 4:00 pm Staff A (administrator) stated, Staff H told me that Resident #9 did not want to eat, and he complaint of on his , and Staff G requested Staff H to call the ambulance and sent him to the hospital. I did not ask to call the doctor; I asked Staff H, if she offered him to eat something else, and Staff H replied, "Yes, I did, but he refused it. We really know our residents, and we know when they have a change of health or want to go to the hospital. He used to eat really well, and communicate with staff. Resident #9 usually never complained of , . Staff H called a second time, to advise me that the ambulance was in the facility, and they did the and the Rescue came after, and took over, but he . According to the girls (staffing present) Resident #9 was breathing and his were opened, and the ambulance did the . However, I think that the ambulance employees would not start if he would be ."

Interview on at 4:05 pm Staff G stated, "I am the owner of the facility. The staff called me because Resident #9 did not want to eat because he had , , and he refused to eat. Staff offered him something else to eat, but he refused, and they asked him if he wanted to go to the hospital, and he said, "Yes." Next, Staff G stated, "I took the decision to send him by ambulance because he was walking, alert, responsive, not , and breathing with normally. Therefore, I did not want to call fire rescue for a non-emergency because they do not like it when you call for non-emergency. I told them to call the ambulance and send him to the hospital. A few moments later, Staff F called me and stated something weird is happening to him because he to the bed, and at the same time Staff H was dialing 911. Staff F told me, "The ambulance is here and staff opened the door, and the ambulance started . The rescue came after them, and they took over and the ambulance left. I was informed by rescue that Resident #9 was declared .

Class I