STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968498	**04/08/2019**
NAME OF PROVIDER OR SUPPLIER **SOLUTIONS HOME CARE SERVICES II, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **16910 SW 119 AVENUE** **MIAMI, FL 33177**	

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

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c); 59A-35.090(2)(d)-(3)

Based on record review and interview, the facility failed to ensure that Attestation of Compliance with Background Screening Requirements form was completed upon hire one out of five sampled staff (Staff C).

Findings included:

Review of Staff C's personnel record showed that hire date was on . . . . . The Attestation of Compliance with Background Screening Requirements form did not have Staff C's signature, title, or date.

Review of the Staff schedule showed that Staff C was scheduled to work from Sunday . . . . . thru Friday . . . . from 7 PM through 7 AM.

On . . . at 7:45AM, Staff B revealed Staff C worked from Monday to Friday from 7 PM to 7 AM.

Class III

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0000 - Initial Comments

A biennial survey was conducted at Solutions Home Care Services II, 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 record review and interview, the facility failed to maintain updated progress notes for one out of five (Resident # 3) sampled residents who was transferred to the hospital.

Findings included:

A review of Resident #3's record showed an admission date of . . . and there was no documentation that resident went to the hospital or any progress notes after the resident went to the hospital. Hospital discharge papers found in Resident #3's record showed that he went to the hospital on for an , ( ).

On at 2:07 PM, the Administrator stated that she had forgotten to update the resident's progress notes and will update them.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review and interview, the facility failed to ensure the Medication Observation Records (MORs) had a specific time each medication took for one out of five sampled residents (Resident # 1).

Findings included:

A review of the medication observation record (MOR) shows Resident #1's medications are only labeled as "AM/PM".

On at 8:48 AM, Licensed Practical Nurse from hospice company revealed that she gave medication to the residents just in the morning. The resident received medications usually between 7 AM and 8 AM. There was an accident on the highway and it caused her to be late. She did not give medications in the afternoon. The one that completed the information for medications was the case manager. She acknowledged that medications need the scheduled time because they can be given one

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hour before and one hour after the scheduled time.

Class III

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

Based on observation and interview, the facility failed to ensure that medications were kept locked in a central storage area at all times.

Findings included:

On at 7:25 AM, observed a tub of 1% Silver Cream placed on top of resident # 1's nightstand. Observed Resident # 1 bed ridden and not able to be interviewed at the time. Additionally, observed Resident #1's room remained unlocked during the time of the survey.

On at 7:26 AM, Staff B stated that she placed the medication on top of the nightstand to have everything ready when the hospice nurse comes to provide medications.

Class III

0077 - Staffing Standards - Administrators - 429.176 FS; 429.52( ),58A-5.019(1) FAC

Based on observation, record review, and interview, the facility failed to appoint in writing a separate manager for each facility that the administrator supervised.

Findings included:

Review of Florida Health Finder and background screening database showed that the administrator supervised two assisted living facility.

On at 10:52 AM, Staff B revealed that she sat to take the CORE test but she failed the test.

On at 12:59 PM, the administrator revealed that she submitted the change of administrator to Tallahassee for the other facility. There was not manager appointed to the facility.

Class III

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0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the facility failed to have evidence of a negative examination documented on an annual basis for one out of five sampled staff members (Staff C).

Findings included:

Review of the staff schedule showed that Staff C was scheduled to work from Sunday thru Friday from 7 PM through 7 AM. The administrator was scheduled to work from Sunday to Friday from 7 AM to 7 PM.

On at 7:45AM, Staff B revealed that she worked from Monday to Friday from 7 AM to 7 PM and Staff C from 7 PM to 7 AM. The administrator worked on Saturdays and Sundays from 7 AM - 7 PM.

Review of Staff C's personnel record showed that the last examination was on .

Review of Administrator's personnel record showed that the last examination was on .

Class III

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

Based on observation, interview, and record review, the facility failed to maintain an accurate written work schedule that reflected its 24-hour staffing pattern.

Findings included:

A review of the Employee's schedule showed the following shifts for Wednesday ( ): the Administrator and Staff B from 7 AM through 7 PM and Staff C from 7 PM through 7 AM. The Employee's schedule did not reflect any staff working from 7 AM - 7 PM on and showed that Staff D worked at 7 PM through 7 AM.

On at 7:20 AM, observed Staff B cleaning the kitchen and Staff E doing laundry and cleaning the resident's rooms. At 8:26 AM, observed the administrator arrive to the facility.

On at 7:45AM, Staff B revealed that she worked from Monday to Friday from 7 AM to 7 PM and

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Staff C from 7 PM to 7 AM. The administrator worked on Saturdays and Sundays from 7 AM - 7 PM.

On at 12:46 PM, the Administrator stated that she covered the 7 AM - 7 PM shift on Saturday and it was a mistake to not have corrected the schedule. The administrator also stated that Staff E was going to work from 7 PM - 7 AM the night of the survey since she received training during the day and would include her on the schedule moving forward.

Class III

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

Based on observation and interview, the facility failed to maintain all existing architectural, mechanical, electrical and structural systems, and appurtenances in good working order.

Findings included:

On at 7:30 AM, observed the facility's kitchen sink missing a portion of its kitchen counter and a missing kitchen cabinet door.

On at 1:04 PM, the administrator stated that the cabinets recently broke on Monday and would have it fixed soon.

Class III

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

Based on observation and record review, the facility failed to verify all information was completed on a health assessment for one out of five (Resident #2) sampled residents. The facility also failed to have an updated health assessment completed after a significant change for two out of five (Resident # 1 and # 2) sampled residents. Furthermore, the facility failed to maintain accurate information on the 30 Days Notice Rate Increase document for one out of five (Resident # 1) sampled residents.

Findings included:

Review of Resident # 1's record showed on the last health assessment completed on that Resident # 1 had a

Review of Resident #1's hospice visit notes showed that on the resident had a

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, that had measurements of 4 cm of length, 4 cm of width, and 0 cm of deep. She had a , in the with measurements of 0.2 cm of length, 0.3 cm of width, and 0.3 cm of deep with between o clock of 2 cm on . Interdisciplinary Care Plan for the period of to showed that she was bedbound and had a doctor order on for , right big , and right .

On at 9:22 AM, the hospice nurse uncovered the for Resident #1. She has an opened area on heel. It had , no drainage. It looked on the healing process.

A review of Resident # 1's record showed that there was a 30 Days' Notice Rate Increase on from $700 to $800 a month effective ; however, Resident # 1's residential agreement stated that in addition to the monthly fee, the facility will receive an additional $1,200 a month from the resident's Long Term Care (LTC) benefit. Further record review shows that the LTC amount was not reflected on the 30 Days' Notice Rate Increase.

2) Review of Resident # 2's record showed the last health assessment with date of completion on did not have any documentation of the name, the telephone number, and the address of the examiner. Also the most current health assessment for her showed that she did not have any , 3, or 4 , .

Review of Resident #2's hospice visit notes showed that on the resident had an , on the left heel. It had measurements of 1.6 cm of length, 1.5 cm of width, and 0.2 cm of deep. She had an , on the left heel with measurements of 0.2 cm of length, 0.1 cm of width, and 0 cm of deep on .

On at 8:55 AM, the hospice nurse uncovered the left heel for Resident #2. Resident #2 had an opened area on left heel. It had circular shape with pink bed, no drainage.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation and interview, the facility failed to obtain the required fuel (48 hours worth of fuel) necessary to operate in the case of the loss of a primary electrical power. The facility also failed to implement policies and procedures to ensure their facility can effectively activate and immediately operate while using an alternative power source. Furthermore, the facility also failed to have a monoxide detector on site.

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Findings included:

On . . . . . at 11:50AM, observed a new generator concealed in its original box unopened in the facility's garage. Additionally, there were two empty gas tanks located in the outside patio.

On at 11:55AM, the Administrator stated that she never tested the generator because it is brand new and assumed that it would work perfectly fine. The Administrator also stated that she does not know how many gallons of gas the generator needs to function and would go to the nearest gas station to fill the empty gas tanks in the case of an emergency. In addition, the Administrator stated at 1:30PM that she does not have a monoxide detector and will add one soon.

Class III