STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967595	**04/04/2019**
NAME OF PROVIDER OR SUPPLIER **GOLDEN TOUCH HOME CARE #2**	STREET ADDRESS, CITY, STATE, ZIP CODE **900 NE 205 STREET** **MIAMI, FL 33179**	

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

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review and interview, the facility failed to update it's roster in the background screening clearinghouse with any changes in the employment status of three out of six sampled staff within 10 business days (Staff E, F and G).

Findings included:

A review of the staffing schedule showed Staff E, F and G were no longer working at the facility.

Review of employee roster database showed that Staff E's provisional hire date was [redacted] and there was no end date. Staff F's hire date was [redacted] and there was no end date. Staff G's hire date was and [redacted] there was no end date.

On [redacted] at 8:33 AM, the Administrator stated Staff E, F and G quit working at the facility over a month ago and she removed the employees from the Background Screening. She stated she did not know why it was not showing up.

Unclassified

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0000 - Initial Comments

A relicensure survey was conducted at Golden Touch Home Care #2 on , through 4th , 2019. The facility had deficiencies identified at the time of the survey.

0004 - Licensure - Requirements - 58A-5.016 FAC

Based on observation, interview and record review, the facility failed to maintain licensure requirements.

Findings:

Record review showed that the facility received Resident #1's check directly. On at 12:21 PM, the Administrator was asked if she had a surety bond, she said no.

On at 11:00, observed that the facility's liability insurance documentation was not posted with the other records. At 11:17 am, the administrator stated the company sent her a renewal email so that she could update it in time for her license renewal. She stated that she currently had no liability insurance.

7. On at 08:10 am, observed the facility's generator in a box in the shed, with 5 gallons of gas next to it. The Administrator stated "We cannot have 96 gallons of gas onsite. That's how much the generator needs for 48 hours. The neighbors are worried. I keep five gallons and I will get the rest when it's time."

On at 11:31 am, the Administrator stated that she did not have the Emergency Power Plan (EPP) policies and procedures onsite because she got an EPP approval. She was observed going to the of her car when asked to provide documentation that staff were trained and residents notified of the generator and EPP, and returned with some papers from her , which were general emergency procedures unrelated to the EPP. She stated that she had taken them home to update them.

Class III

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

Based on observation, interview, and record review, the facility failed to ensure that one of five sampled residents met the criteria for continued residency (Resident #2). The resident needed medication

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administration, on the floor, and demonstrated behaviors.

Findings:

1. On at 6:38 am, observed Resident #2 lying in a bed. The bedroom had strong odor. Staff B reported that the resident walked around at night and on the floor. Observed the room to have a bed and closet, but no dresser or nightstand. Staff B stated "This one has to pee on the floor. We put everything down for him but he won't go to the bathroom or anything. He just walks around all night."

2. On at 8:07AM, observed Staff B pour the medications in Resident #2's .

On at 10:12 AM, Staff B said that she gave Resident #1 medications by dissolving the medications in water and poured the mixture into his .

On at 10:12 AM, Staff B stated Resident #2 was unable to take the medications on his own and needed a lot of help.

3. On at 11:09 AM observed Resident #2 walk to the door and attempt to go out. The door was slightly open. Staff C went after the resident and stopped him from walking out the door. Observed the resident repeat this action three more times over the next three hours. The Administrator had said around 8:30 am, when asked whey the resident's health assessment advised elopement precautions, that Resident #2's assessment as at risk of was no longer accurate, and that it must have been written when he was younger, since he could barely walk (this was why no elopement precautions were in place). At 11:14 the Administrator stated that Resident #2 had no ID on his person, and that he couldn't open the door. A review of the resident's record showed no elopement risk assessment . Observation of the resident showed no visible identification. An attempt to interview the resident failed when he was unable to respond. A review of the resident's heath assessment showed diagnoses of with behavioral manifestations, latent , risk for , II, , and . Physical/sensory limitations showed severe or behavior needs showed 'Oriented to self only, with poor awareness.' Elopement risk showed 'yes'.

On at 11:20 am, a second request was made to the Administrator for elopement drill records and policies/procedures. Observed a car drive up outside. At 11:29 am when asked if the documents presented came from outside of the facility, the Administrator shrugged and said yes. She further stated "you know, sometimes I take the books home and work on them." There was no documentation of polices/procedures regarding elopement.

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4) On at around 1:00 pm, the resident's health plan care manager stated that the resident had been removed from the facility and placed at a location where he could receive medication administration and other needed supervsion from qualified staff.

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 treat one of six sampled residents with consideration and respect with due recognition of personal dignity, individuality, and the need for privacy (Resident #4). The resident was in a shared room where he used a bedside , and no privacy divider was in place.

Findings Included:

On at 6:40 AM observed Resident #4 with a half full at bedside. Observed Resident to have a roommate and no privacy divider in place. Resident #4 confirmed that he used the at bedside while his roommate was present.

On at 6:40 AM, Staff B stated the Residents were both men.

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 as outlined by the state when assisting two out of six sampled residents with self-administration of medications (Resident #1 and #2).

Findings Included:

On at 8:07 AM, observed Staff B prepared medications for Resident #2. Observed several medications drop on the kitchen counter and Staff B picked up the medications with her in placed in the medicine cup. Observed Staff B mixed the medications with water. Observed Staff B pour the medications in Resident # 2's .

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On at 8:07 AM, Staff B stated she mixed the medications in the water because Resident # 2 would not swallow the medications whole. She stated Resident # 2 was unable to take the medications on his own and he needed a lot of help.

On at 10:12, Administrator stated the facility staff gave Resident # 1 his medications. Staff B said that she gave Resident # 1 medications the same way she gave Resident # 2 medications by dissolving the medications in water and poured the mixture into his . She stated Resident # 2 could not take the medications on his own.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, record review and interview the facility failed to ensure that only licensed staff administered medications to 2 out of 6 sampled residents (Resident # 1 and # 2). Resident #1 and #2 medications were administered by a staff member that was not licensed .

Findings Included:

Employee Record Review showed Staff B was not licensed to administer medications.

On at 6:40AM, Staff B stated Resident # 1 had a , . Staff B stated that the Hospice nurse usually put cream on the , but that morning she did it, when she was changing his adult brief.

On at 8:07AM, observed Staff B pour the medications in Resident # 2 .

On at 10:12, Administrator stated the facility staff gave Resident # 1 his medications. Staff B said that she gave Resident # 1 medications the same way she gave Resident #2 medications by dissolving the medications in water and poured the mixture into his .

On at 10:12 AM, Staff B stated Resident # 1 and # 2 was unable to take the medications on their own and needed a lot of help.

Class III

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

Based on observation and record review, the facility failed to failed to maintain an accurate Medication Observation Record (MOR) for one of six sampled residents (Resident #2).

Findings:

A review of the MOR for Resident #2 showed that the resident's administration was signed as given by the unlicensed facility staff (Staff B) the day before. Further review showed the initialed with the letter R for the date of the inspection.

On at 10:29 am, the Administrator stated that her staff did not sign for the . When she was shown the MOR, she just shrugged. Review of the MOR for Resident #2, showed that administration had been signed by an unknown person. The Administrator stated the day program provider's nurse had signed. There was no documentation of nurse signatures on the of the MOR in the area designated for nursing signatures.

Class III

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

Based on observation and interview the facility failed to ensure medications were stored in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times. Unlocked medications were accessible to all Residents.

Findings Included:

at 7.50 AM, observed for Resident #1 and Resident # 3 inside an unlocked standard sized refrigerator in the kitchen/day room area where the residents sat to watch television. The was inside of Ziploc bags or silver insulated bags.

On at 7:45AM, the outside agency nurse stated the medications could not be locked because the outside agency's rule was that only the currently being used can be locked in the lockbox.

On at 7:45AM observed outside agency nurse spread the medications for Resident # 1 and # 3 over the kitchen counter, walk away and left the medications unattended and medications were accessible to all Residents.

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On at 6:40AM observed a jar of prescription on nightstand of Resident # 1 .

On at 6:40AM Staff B acknowledged the belonged to Resident # 1 and it was kept on the nightstand.

On at 12:21PM, the Administrator stated she trained her staff to ensure all medications were kept locked and never unattended. She said she will speak to the outside agency nurses about not leaving medications unattended.

Class III

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

Based on observation, interview and record review, the facility failed to ensure that it was under the supervision of a qualified administrator who was responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents . The administrator was operating two facilities, and no manager was in place.
Findings:

1. On at 6:30 am, observed no documetatinon of the facility's designation of a manager posted onsite. Review of facility provider locator database showed that she was listed as administrator at two assisted living facilities.

On at 11:32 am, the Administrator stated she did not have a manager because she is not the administrator at her second facility. At 11:49 am the Administrator stated that she didn't change the listed administrator at the other facility because the administrator at the other facility had not yet passed the core training and examination.

Class III

0081 - Training - Staff In-Service - 58A-5.0191( ) FAC

Based on observations, record review, and interview, the facility failed to ensure that 2 out 3 sampled staff received a two hour pre-service training prior to interacting with residents. (Staff C and D).

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Findings Included:

Record review showed personnel records for Staff C and D hired . . . . . contained no documentation of the pre-service training in file.

On at 12:21PM the Administrator stated she would train the staff.

Class III

0083 - Training - First Aid and - 58A-5.0191(5) FAC

Based on record review and interview, the facility's personnel records did not include properly documented evidence of First Aid and training for one out of three (Staff B) sampled staff.

Findings included:

On . . . . . at 6:30 am, observed Staff B on duty alone, caring for six residents.

Employee record review showed no documentation of valid and current First Aid and Training for Staff B.

On at 12:21 PM, the Administrator stated Staff B missed the training day and needed to be rescheduled.

Class III

0085 - Training - Nutrition & Food Service - 58A-5.0191(7) FAC

Based on observation, record review and interview, the facility failed to have the person designated by the administrator as responsible for the facility ' s food service (Staff B) trained annually in a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility.

Findings Included:

On at 7:00 AM observed Staff B preparing and serving meals to the residents.

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A review of Staff B's employee record showed no documentation that the staff received the required food service designee training.

On at 12:21PM, the Administrator stated she thought Staff B had the training in her file.

Class III

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

Based on record review and interview, the facility failed to provide a completed employment application for one of six sampled staff (Staff C) that included references.

Findings Included:

On , review of the employee record showed Staff C had a hire date . No employment application or references were found.

On at 12:21 PM, the Administrator stated she thought Staff C had an employment application and references in her file. She's stated she would make sure Staff C completed an employment application.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation and interview, the facility failed meet the requirements of the Emergency Power Plan (EPP). The facility did not store gas onsite to power the generator for 48 hours in the event of a loss of primary power. The facility failed to provide documentation of the EPP policies and procedures, and failed to ensure that residents/their families or the staff were informed of the policies.

Findings:

On at 7:48, when asked about the facility's generator, Staff B says she didn't know what a generator was or where it might be. She opened the door to show the hot water heater, asking if that was the generator.

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On at 08:10 am, observed the facility's generator in a box in the shed, with 5 gallons of gas next to it. The Administrator stated "We cannot have 96 gallons of gas onsite. That's how much the generator needs for 48 hours. The neighbors are worried. I keep five gallons and I will get the rest when it's time."

On at 11:31am, the Administrator stated that she did not have the EPP policies and procedures onsite because she got an EPP approval. She was observed going to the of her car when asked to provide documentation that staff were trained and residents notified of the generator and EPP, and returned with some papers from her , which were general emergency procedures unrelated to the EPP. She stated that she had taken them home to update them.

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