STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966123	**05/03/2019**
NAME OF PROVIDER OR SUPPLIER **GRACE CARE FAMILY HOME, CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **4221 WEST 5 LANE** **HIALEAH, FL 33012**	

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

Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on record review and interview, the facility failed to maintain documentation of an eligible level II background screening for one of six sampled staff (E).

Findings included:

Personnel record review revealed no documentation of an eligible level II background screening for Staff (E).

On [redacted] at 12:00 pm, Staff B stated, "I am working on Staff E's file; she recently starts to work here."

Class III

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

Based on record review and interview, the facility failed to update the employment status for one of five sampled staff (E) on it's roster in the background screening clearinghouse.

Findings included:

A review of the facility's roster in the background screening clearinghouse revealed that Staff E was not listed.

On [redacted] at 12:00 pm Staff B stated that Staff E started to work recently.

Unclassified

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0000 - Initial Comments

A complaint investigation (complaint number 2018018325) was conducted on - at Grace Care Family Home Corp. The facility had deficiencies 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 provide adequate supervision and failed to implement a plan of action to prevent continued for two of six sampled residents (Residents #1 and #6), hospitalized due to injuries from . The facility also failed to maintain updated observation records for two of six sampled residents (Residents #1 and #6).

Findings included:

1) A review of Resident #1's health assessment (dated) showed diagnoses of , , , and . Resident #1 needed a walker to ambulate, needed precautions, and needed supervision for transferring and assistance for ambulation.

Resident #1's hospital discharge record stated under additional information (dated), "Patient's physician: S/P while taking a shower in the ALF. As per caregiver in ALF patient developed a left sided droop and right arm ."

On at 12:00 pm, Staff B stated Staff B revealed Resident #1 and was hospitalized twice. Resident #1 on and . Staff B stated, "Resident #1 went to the hospital on , too."

Record review revealed the facility did not have Resident #1's observation log updated. The facility did not document Resident #1's and/or hospitalizations on , , and . In addition, the facility did not write a plan of action, or implement precautions to prevent Resident #1 from falling.

On at 12:30 pm Staff B stated, "I have a consultant, and she writes all the incidents in the residents' records; I do not know why the consultant did not write Resident #1's and hospitalizations."

On at 12:30 pm Staff B stated, "On Resident #1 ; I was here and I heard something in the bathroom and observed Resident #1 sitting on the bathroom floor. I was here, and she had a . She did not ; she was sitting on the floor. She was breathing but weak, rescue did an electro, but it

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was okay, but they observed, as well as me, her , and little . They took her to the hospital for further observation."

On at 2:00 pm, Staff B stated, "Resident #1 for first time on at 7:30 pm; she in front of the entrance door because she was trying to get out from the house. Resident #1 stepped on her blanket and . She had a fissure in her right . We called rescue, and they took her to the hospital and she returned on . Staff B states that Resident #1 on 11/ 2/ 2018 at 8:30 pm, Staff F was working in the facility, and resident in her room when she was going to the bathroom. Rescue came and took her to the hospital and she came on ."

On at 2:00 pm Staff B stated, "Resident #1 felt on at 6:30 am in the bathroom, the rescue came, checked resident, and put her in bed, and she was okay, and she did not go to the hospital. After this , between 5th and 6th of , DCF (Department of Children and Families) came to the facility due to a complaint from hospice nurse.

Interview on at 11:04 am Hospice Nurse A stated, "We had a complaint from two of ours HHAs (Home Health Aides) regarding Resident #1. They observed that Resident #1 had a in her , and she was missing a . Our staff stated that the resident complained of being abused by the facility's Staff F, and she in the facility. Hospice policy is to report any incident with the residents; therefore, we reported to DCF, and an investigator went to the facility.

On at 3:25 pm Staff B stated, "We talked with the staff, to increase supervision. I have nothing in writing and we have no risk management policy. We did not write an internal incident report, either. We did not re-train staff on residents' rights, incident report, and neglect."

On at 9:12 am Hospice Nurse B stated, "I noticed Resident #1 afraid, and she told us that the staff hit her. I do not see the facility's staff hitting Resident #1, but I saw the on her , forehead and a missing , which after asked, we found out that were caused by her .

On at 9:18 am Hospice Nurse C stated, "I never saw Resident #1 being abused. However, she told us that the facility's Staff F hit her, and Staff F was tough with her. We also saw her , which happened after her .

Record review revealed that the facility's schedule dated stated, "Staff B and E are working from 7 am - 7 pm." Further record review revealed that the facility had four of six residents listed on precautions."

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On at 9:50 am Resident #5 revealed that the facility had one staff working every day, and Staff C and D worked one or two days a week.

On at 10:00 am Resident #6 stated, "Staff B comes when AHCA (Agency for Health Care Administration) is here, he does not work here, he comes once a week. Staff E is here daily, she works alone; she has one day off. It has been like that all the time, we used to have another staff before Staff E came, but she is no longer working here, and she used to be here every day working alone, too.

2) A review of Resident #6's health assessment (dated) showed the resident needed precautions and supervision with ambulation, bathing, grooming and .

On at 11:50 am, Staff B stated Resident #6 was disoriented on her first day living in the facility; therefore, she two times. 'The first was on at 7:00 pm in the sitting area, the rescue came, and they did not take her because she was okay. On at midnight, she from bed, but she stood up herself, we found out after she told us. Resident #6 did not complaint for , and she did not get hurt, in my interpretation, due to her , she could not be able to stand again by herself.'

On at 9:34 am Resident #6's family member stated, "I knew that my sister two times the day she arrived to the facility because she told me. The facility never informed me that she . I was surprised they did not sent her to be seen for a doctor. I visit my sister every Saturday, I only see Staff D working on Saturdays, I have not seen another staff beside Staff C at first, and now Staff D."

Class II

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

Based on record review, and interview, the facility failed to treat one of five (Resident #5 and #6) sampled residents with dignity and respect.

Findings included:

On at 1:20 pm Resident #5 stated, "Staff D has , she does not treat everyone the same. She is a hypocrite."

On at 1:24 pm Resident #6 stated, "I do not like Staff D, I feel nervous just thinking about her, and she make me feel sick."

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On at 9:30 am Resident #6 stated, "I want to talk about the meals; especially dinner time because they do not provide varied food. We have three days without butter for the bread. The dinner is bad."

On at 10:00 am revealed that a refrigerator on the porch, had some burgers (seven) inside, with no date of expiration. The kitchen's refrigerator had some mini-burgers inside plastic bags (nine) with no expiration date.

On at 3:00 pm Staff B stated, "The burgers are fresh, but I removed the box, which had the expiration date on it."

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC 429.52 (6), FS

Based on record review, and interview, the facility failed to ensure that one of six sampled staffs (E) received the required training on providing assistance with self-administration of medications.

Findings included:

Record review revealed a certificate stating that Staff E had received two hours of training to assist residents with self-administration of medication dated . There was no documentation of the initial six hour required training.

Record review revealed that Staff E signed the medication observation logs for six residents on .

Interview on at 10:00 am Staff E stated, "I start to work recently, and I assist with daily living activities, cooking and self-administration of medication, too."

Class III

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

Based on observation, record review and interview, the facility failed to have documentation of Nutrition and Food Service training for one of five sampled staff (E).

Findings included:

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Observation on at 11:00 am revealed Staff E (hired) cooking food for the census of six residents. Further observation at 12:00 pm revealed Staff E serving lunch for the residents.

On at 10:00 am Staff E stated, "I start to work recently, and I assist with daily living activities, cooking and self-administration of medication, too."

Interview on at 1:20 pm Staff B acknowledged that Staff E's record had no documentation of training on Nutrition and Food Service.

Class III

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

Based on observation and interview the facility failed to maintain a safe living environment for a census of six of six sampled residents.

Findings included:

Observation on at 9:30 am revealed that the facility needed to replace or through away the refrigerator at the porch, which painting was pealing and having dark stain.

Interview on at 3:00 pm, Staff B stated, "I will request the owner of the house to replace the refrigerator.

Class III

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

Based on record review and interview, the facility failed to have a complete health assessment for one of six sampled residents (#5).

Findings included:

Record review revealed that Resident #5's health assessment did not have diagnosis information. The section C on page two of five was empty. In addition, it reflected that the facility did not meet Resident #5 needs.

Interview on at 11:00 am Staff B acknowledged that Residents #5's health assessment was

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missing diagnosis information.

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 a one-day and a fifteen-day report with the agency, for one of six sampled residents (Resident #1).

Findings included:

Record review revealed that Resident #1's health assessment (dated) diagnosis as and . Resident #1 needed a walker to ambulate, had precautions and needed supervision for transferring and assistance for ambulation.

Interview on at 12:00 pm, Staff B acknowledged that the Department of Children and Families (DCF) visited the facility due to Resident #1's . Staff B stated that DCF visited the facility on 11/5/18 due to hospice's staff complaint. However, Staff B stated, "I did not know that I have to write an adverse incident report to AHCA if DCF visit the facility on regard of any resident."

Class III