STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967911	**04/09/2019**
NAME OF PROVIDER OR SUPPLIER **VANDOR HOMECARE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2110 NORTH 46TH AVENUE HOLLYWOOD, FL 33021**	

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

0000 - Initial Comments

A biennial Relicensure survey commenced on and concluded on at Vandor Homecare, Inc. The facility had deficiencies at the time of the survey.

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

Based on observation, interview and record review, it was determined that the facility failed to reassess a resident for continued residency after the resident exhibited a significant behavior change and posed a danger to himself and other residents, for 1 of 2 sampled residents (Resident #1). As evidence of the facility failure to assess Resident #1 with respect to his significant behavior changes to ensure the facility could meet the care needs of this resident , including supervision and monitoring needs.

The findings included:

During an observational tour of Resident #1's room on at 9:05 AM revealed a hospital bed with ½ side rails, a closet with clothing and shoes. Upon entrance, the room was dark and the resident was observed sitting on his bed chewing on the bed linen. When the observational tour was finished the staff member was observed physically locking the door from the outside so that the resident would not be able to gain entry to the common areas of the facility, the staff member stated, "we have to". Throughout the day of the survey, the resident was only observed out of his room to eat lunch.

During the medication observation on at 12:00 PM, upon entrance into Resident #1's room, the resident room was dark upon entrance. The staff member was observed unlocking the room door, turned the light on and as she exited the room she turned the light off, leaving the resident locked in the dark room. The staff member was physically observed unlocking and locking the door.

An interview was conducted with Staff A on at 12:30 PM, after observing the staff member twisting the lock from exterior part of the door to gain entry into the room. At this time, the staff member stated that Resident#1 has to be locked inside of his room or he will come out of his room and touch everything, eat everything, go in the other resident rooms, lay in the other resident beds and cause an overall disturbance within the facility. She further stated he would also go in the garbage and start eating out of the garbage can in the kitchen. The resident would also go to the bathroom garbage and start eating his own feces out of his diaper and eating other soiled items out of the garbage. She further stated for his own safety and protection locking him in his room is the best thing for him. The staff member stated when she is busy cooking, cleaning, taking her lunch break and doing other duties, she locks Resident #1's room door. She further stated I keep the door lock because most of the time it's me

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alone here and the Administrator come and go.

An interview conducted on at 2:01 PM with the Administrator, at this time, she stated when she admitted Resident #1 in his facility he was very aggressive and was total with at least 4 of his activities of daily living. It was stated "if we don't keep Resident #1 locked inside of his room he will eat his own feces, eat out of the facility garbage can, he would chew on everything in the facility including personal protective equipment such as gloves and disturb the other residents" and; she further stated I she can't have that.

An interview was conducted with Resident #1's Guardian on at 8:01 PM. The guardian stated she was aware of the resident being locked in the room because the facility stated that was there means of controlling him from getting into everything. She stated at first she didn't agree with it and she was unsure if that was suppose to happen but she trust the facility and went along with the recommended course of action. She further stated that being locked in a room could not be healthy for anyone mental health and wanted her brother to be involved in some type of activities, instead of being locked inside of the room for majority of the day or at the convenience of the facility. She further stated she knew her brother was very difficult to handle but the facility kept him clean and the facility in itself was clean.

The Administrator took out her phone and scrolled through her gallery showing pictures of Resident #1 sitting inside of the bathroom eating his own feces out of his soiled pamper that was inside of the garbage can, a picture was also shown of Resident #1 taking a cushion of the chair and sitting so far deep in the chair that the resident's skin; was pierced by the wood and nails in the furniture, in which the resident suffered an injury to his . The Administrator stated Resident #1 would also take off his pamper and smear feces all over the walls. She further stated Resident #1 would take towels in the facility, put the towel in the toilet and then take the towel out of toilet and put the towel in his drinking the toilet water. The Administrator stated "we can't watch him 24 hours and 7 days a week, so locking in the room was the best resolution".

The Administrator stated the family members informed her that {unethical ritual} was done to the resident (prior to admission to the facility) and that is why the resident exhibits these behaviors. She stated they have reached out to the resident's physician for medication management when he began eating his own feces in . She indicated they ordered the highest medication regimen but he still exhibits the same behaviors of wanting to eat everything, including his own feces. The Administrator stated she had to seek adult onesies so he could stop taking off his pamper to eat his own feces and that seemed to help but the medication never stopped that type of behavior. The Administrator stated

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the family members are aware that they lock the resident inside of his room due to the resident; erratic behavior; she even increased the resident's monthly fee due to the increase service the resident requires. She further stated, the resident had other furniture inside of his room, it was originally a shared room but due to the resident pulling out the drawers and destroying the furniture, she was afraid he might hurt himself so she took all of the furniture out of his room and left him with only a bed and his clothing and shoes in his closet.

At this time, the Administrator confirmed the resident was total with four of his activities of daily living (bathing, , self-care - grooming and toileting). At this time, she also confirmed all medication must be administered to Resident #1 and the resident is currently not on hospice. The Administrator stated she tried to get him admitted to hospice but during the consultation and evaluation, the resident did not have a qualifying diagnosis for hospice services.

Record review of the resident sheet revealed the resident was admitted to the facility on from a Community hospital. Resident #1's Health Assessment form (1823 AHCA form) dated listed a diagnosis of major with , required medication administration. The 1823 form further stated the resident required 24 hour nursing or care and that the residents needs could not be met in an assisted living facility. Record review of Resident #1 most recent 1823 form (undated) however, the Administrator confirms it was the most recent 1823 and the assessment was done in . The resident diagnosed with and behavioral disturbances, the resident has limitations on fine motor skills, poor insight, poor judgement, nonverbal and does not follow commands. The 1823 form further stated the resident required total assistance with four out of six activities of daily living (bathing, , self-care and toileting).

Record review also revealed the facility progress noted dated stated Resident #1 began sleeping for short periods during the day and began taking off his clothes. Also, it was noted, that the resident would raise his fist as if he is going to hit someone. On , it was noted the resident would continuously take his diaper off. The resident was observed and forth within the facility. On at 1:30 PM it was noted the resident took off his pants and diaper, sat on the dining room chair and on himself. On at 2:30 PM, it was noted the resident was in his room taking his clothing out of the closet and chewing on it.

Further record review also revealed the facility contacted Resident #1's physician regarding his behavior of eating his feces and drinking the toilet water. The physician advised the Administrator to send the resident out to the local hospital. The progress notes stated the resident was and admitted into the hospital, the resident was admitted on - . When the resident was

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discharged from the hospital he was discharged with new medication orders ( ), the new orders could not be located within the facility records.

An interview was conducted with Resident #1's Guardian on at 8:01 PM. The guardian stated she was aware of the resident being locked in the room because the facility stated that was there means of controlling him from getting into everything. She stated at first she didn't agree with it and she was unsure if that was suppose to happen but she trusts the facility and went along with the recommended course of action. She further stated that being locked in a room could not be healthy for anyone mental health and wanted her brother to be involved in some type of activities, instead of being locked inside of the room for majority of the day or at the convenience of the facility. She further stated she knew her brother was very difficult to handle but the facility kept him clean and the facility in itself was clean.

Further observations on at approximately 11 AM of Resident #1 after surveyor intervention, resulting in the facility allowing the resident out of the locked room revealed the resident was extremely and exhibited numerous behavior concerns (as previously stated by the Administrator and staff). The resident required constant redirection and one-on-one supervision. This would make it extremely difficult for 1 staff member in the facility to provide supervision to Resident #1 (based on his behavior) and the other residents of the facility. It was also confirmed through staff interviews that more than 1 staff member is not always present in the facility. This was also confirmed upon arrival to the facility on , in which only 1 staff member (Staff A) was present.

During the exit interview with the Administrator on and , she confirmed aforementioned. The Administrator provided no additional information.

Class II

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

Based on interview, observation and record review, the facility failed to honor resident rights, for 1 out of 2 sampled residents (Resident #1). As evidence of the facility isolating Resident #1 in his room and locking the door (lock on outside of the door, controlled by staff) preventing the resident from exiting and entering the room at his/her leisure(free-will).

The findings include:

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During the medication observation on at 12:00 PM, upon entrance into Resident #1's room, the resident room was dark upon entrance. The staff member was observed unlocking the room door, turned the light on and as she exited the room she turned the light off, leaving the resident locked in the dark room. The staff member was physically observed unlocking and locking the door.

An interview was conducted with Staff A on at 12:30 PM, after observing the staff member twisting the lock from exterior part of the door to gain entry into the room. At this time, the staff member stated that Resident#1 has to be locked inside of his room or he will come out of his room and touch everything, eat everything, go in the other resident rooms, lay in the other resident beds and cause an overall disturbance within the facility. She further stated he would also go in the garbage and start eating out of the garbage can in the kitchen. The resident would also go to the bathroom garbage and start eating his own feces out of his diaper and eating other soiled items out of the garbage. She further stated for his own safety and protection locking him in his room is the best thing for him. The staff member stated when she is busy cooking, cleaning, taking her lunch break and doing other duties, she locks Resident #1's room door. She further stated I keep the door lock because most of the time it's me alone here and the Administrator come and go.

An interview conducted on at 2:01 PM with the Administrator, at this time, she stated when she admitted Resident #1 in his facility he was very aggressive and was total with at least 4 of his activities of daily living. It was stated "if we don't keep Resident #1 locked inside of his room he will eat his own feces, eat out of the facility garbage can, he would chew on everything in the facility including personal protective equipment such as gloves and disturb the other residents" and; she further stated I she can't have that.

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anyone mental health and wanted her brother to be involved in some type of activities, instead of being locked inside of the room for majority of the day or at the convenience of the facility. She further stated she knew her brother was very difficult to handle but the facility kept him clean and the facility in itself was clean.

Further observations on [redacted] at approximately 11 AM revealed Resident #1 remained in his locked room until surveyor invention, in which the facility staff unlocked the door. At this time, the resident immediately came out of the room.

During the exit interview with the Administrator on [redacted] and [redacted], she confirmed aforementioned. The Administrator provided no additional information.

Additional findings at A 0010
Class II

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

Based on observation and interview, the facility failed to follow the proper procedures for providing assistance with self -administration of medication, for 1 out of 1 residents (Resident #1) observed during medication pass.

The findings included:

Medication observation on [redacted] with Staff A (unlicensed staff member) at 12:30 PM found Resident #1 receiving [redacted] 250 mg tab. Staff A sanitized her [redacted] and picked a cup that was observed to be pre poured into a medicine cup, Staff A then retrieved a mixed fruit cup stating she have to give the resident his medication with food or else he wont take it. Staff A went inside of the resident room and informed the resident it's time to take his medication. Staff A was observed administering the medication to the resident. Staff A observed him swallow the medication. Staff A failed to obtain the medication from its original package, failed to compare the label to the MOR and failed to sign the MOR book.

An interview was conducted on [redacted] at 12:34 PM with staff A, she stated the Administrator pre-poured the medication for the residents because Staff A is not a nurse nor certified nursing assistant. She also stated the Administrator is not a nurse either. It was further stated that she is up to date on her medication training. Staff A further stated the resident requires administration and if we don't administer he won't take the medication. The staff member was informed at this time only a nurse can

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administer medication(s) and put medication(s) into a pill organizer. She was also informed that she must always have the MOR and the medication label available to compare and reconcile.

An interview was conducted on . . . . . at 1:34 PM with the Administrator, she confirmed that she pre- pours all resident medication because she was under the impression that someone with a license has to give medication and sign the MOR book. She confirmed at this time that Resident #1 required medication administration. She further stated that she would get a refresher training for all employees on the medication process.

During the exit interview with the Administrator on . . . . . and . . . . . , she confirmed aforementioned. The Administrator provided no additional information.

Class III

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

Based on record review and interview, it was determined that the facility fail to provide the minimum staffing hours per week for a census of six residents.

The findings included:

A review of the facility staffing schedule revealed the following:

Staff A schedule reflect Friday - Wednesday 6:30 AM - 7:30 PM - Total hours = 78
Staff B schedule reflect Wednesday - Saturday - 7:00 PM - 8:00 AM - Total hours = 52
Staff C schedule reflect Thursday 7:00 AM - 7:30 PM - Total hours = 12.50
Staff D schedule reflect Sunday - Tuesday 7:00 PM - 8:00 AM - Total hours = 39

The staffing schedule . . . . . to a sum of 181.50 hours. The current census is 6, the minimum staffing hours for a census of six should be 212 staffing hours.

During an interview conducted with Staff A on . . . . . at 10:05 AM, she stated the hours always remain the same but sometime she swap her days with the other employees (Staff A, B, C and D).

During an interview conducted with the Administrator on . . . . . at 10:10 AM, she confirmed those were the hours currently running the facility. She also stated sometimes the employee will swap days but that doesnt chnage the hours that are being worked. The Adminsitrator further stated that she is not at

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the facility any set time, she come in and she leave due to working on other projects. The Adminstrator confirmed the findings and provided no further explanation.

During the exit interview with the Administrator on . . . . . and . . . . . , she confirmed aforementioned. The Administrator provided no additional information.

Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on record review and interview, the facility failed to ensure that their Comprehensive Emergency Management Plan (CEMP) was up-to-date and approved by the county entity responsible for approval, as required.

The findings included:

During an interview conducted with the Administrator on . . . . . at 11:05 AM, the facility's CEMP and approval letter were requested for review. The Administrator stated that she was not sure what the status of the CEMP was at this time. She called the local emergency management division and they advised her that the plan was still under review. The last approved CEMP was valid until 11/09/2017. The facility provided a letter of acknowledgement from the local emergency management division dated .

During the exit interview with Administrator on at 3:10 PM , the findings were discussed; no further documentation was provided.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observations, interviews and record, the Assisted Living Facility (ALF) failed to have an approved Emergency Environment Control Plan (EECP) and failed to be in compliance with the regulatory statue requirements.

The findings included:

During a facility tour in regards to the Emergency Preparedness Plan, with the facility administrator, it was revealed that there was no alternate power source, no fuel, nor monoxide detectors

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observed on site at the facility during the tour.

On , the facility was unable to present the facility's emergency plan on for review. The Administrator was unable to provide the surveyor with a written policy and procedure to ensure that the facility could effectively and immediately activate their alternative power source. The facility was unable to provide the surveyor with proof of notification to residents and/or representative upon emergency power plan submission for review and upon final implementation of the plan.

An interview conducted with the Administrator on /019 at 11:10 AM, The facility administrator stated that she submitted everything to the local emergency management division and waiting for the approval.

Class III