STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953342	R 05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROFESSIONAL HOME CARE III, INC	**447 EAST 26 STREET HIALEAH, FL 33013**

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

0000 - Initial Comments

A second revisit to a biennial survey was conducted at Professional Home Care III on and concluded on . Deficiencies were identified at the time of survey.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, record review, and interview, the facility failed failed to contact the family member for one of 23 sampled residents that and was transferred to the hospital for a right . The facility also failed to provider personal supervision for one of 23 sampled residents who had precautions (Resident #7). Resident #7 was observed attempting to walk into an area with a wet floor with no staff supervision. The facility also failed to ensure that three of 13 sampled staff were trained in the policies and procedures on precautioins and do not resusciatate orders.

Findings included:

1) Interview on at 11:45 am with Resident #3's sister revealed, "My brother will not come to that facility. They took him to the hospital, and they never call me. I found out after 11 days because a friend saw him at the hospital. My brother even had a surgery done, and we did not know about him. I called to the facility, and according to them, my brother and broke his , from his bed, which to me, is not that high, he could not explained me how he . She did not advise me about my brother , and they did not call my sister in law either."

Review of Resident #3's progress notes dated revealed, "Resident #3 was still at his bed at 7:25 am and try to turn and roll over to the floor. He is an independent person and walk without a device or supervision. He does not have bedside rails. Staff D, caretaker saw him on the floor and put him on his bed. He complained of , on the , area. Staff D called Staff G, owner at 7:30 am. Staff D called the ambulance company at 7:35 am for possible . Ambulance transfer him at 8:00 am to the hospital." In addition, observation log dated stated, "The sister of Resident #3, decided to voluntary take him to her home by family decision."

Record review revealed Resident #3's health assessment dated had the following diagnoses of (HLD), ( ), Prostatic Hyperplasia ( ), and Tobacco smoker. Resident has a curve posture, memory loss and falling precautions. Resident needed supervision on ambulation, toileting and transferring. Resident needs assistance with bathing,

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eating and grooming. The facility's admission/discharged log reflected Resident #3 was admitted on and discharged on .

Resident #3's record from the hospital stated a male had a with a right unable to stand. Patient admitted on at 9:45 am with a diagnosis of in right .

Interview on at 9:27 am Staff E stated, It was 9:00 am, and Resident #3 from the bed, and broke his . He was sleeping, he from his bed, he started to cry, and we got into his room. We picked him up, and put him on the bed, he was complaining about , we call the ambulance, and they took him to the hospital.

Interview on at 9:43 am Staff B stated, "Resident #3 was sleeping toward the wall, and he turned and from the bed to the floor. He yelled, and Staff D and I went to his room, and he explained why he was on the floor due to he was alerted. He also stated to be on , , and he asked to urinate, we gave him the ; he was alert. Staff D called someone, but I do not know to whom."

Interview on at 2:05 pm Resident #8 stated, "Resident #3 was my roommate. He in our room, he hit his , and he was not able to move it anymore. I did not see him , I saw him on the bed complaining on , . After he left to the hospital, he had not came ."

Interview on at 2:30 pm Staff A and Staff G stated that it was the first time Resident #3 , and he is completely independently. Staff A and G stated that before previous survey the facility used to add precaution on most of the residents' health assessment as risk, for prevention. Resident #3 was a normal resident, and he did not present any changes. We never put half bed rail due to he never needed it. Resident #3 had been living here for a long time. He early in the morning; he rolled over, and from bed. Staffs D called me, and I called the ambulance to take him to the hospital. Staff G stated, "I called Resident #3's Sister, and she did not answer; I called her once, and I documented on his record. However, Resident #3's sister called me."

2) On at 8:41 AM, observed in the common area a bathroom with a wet floor. The facility did not have any signs up that would prevent residents from entering the area. There were no staff members observed near the bathroom. Further observations found Resident #15 walking towards the bathroom to enter. At 8:46 AM, staff was called over to provide assistance to Resident #7.

Review of Resident #7's record showed the resident was at risk for . On at 10:05 AM, observed Resident #7 wearing a yellow armband with the words risk written on the outside.

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On at 3:07 PM, the owner stated all staff were trained on the facility's risk policies and procedures and residents at risk for were supervised.

Record review revealed Staff M was hired on . Interview on at 9:11 am Staff M stated, "I do not still know who is under ( ) or risks."

Interview on at 9:27 am Staff E stated, "I always try not to wet the floor to prevent residents from falling. While I am cleaning the floor, we must have a staff that should be watching to prevent residents from falling; however, we did not have any staff watching today for Resident #7.

Interview on at 9:27 am Staff E stated, "The facility implemented the bracelets in different colors to recognize residents depend on their condition. The white is for residents that are under , red is for residents with LMH condition and I cannot remember the meaning for the yellow one."

Interview on at 9:43 am Staff B stated, Regarding wet floor, we cannot clean the room with the residents in the room, and I am in charge to keep the residents away from the wet floor, and keep them at the main common area. I know that Resident #7 was walking in the wet area, but he is an elderly man, and he forgets that he cannot walk when the door is wet.

Interview on at 10:00 am Staff H stated, "The facility put bracelet to residents with any special condition. The white bracelet is , yellow for and I cannot remember the red one."

Interview on at 2:30 pm Staff A and Staff G stated that the facility provided training to staffs for elopement and risk. Staff A and G also stated, "We classify some residents with a bracelet for the staffs; they will recognize residents under , elopement risk and precaution for the color of the bracelet, such as, red for elopement, yellow for risk and white for .

Class III
Uncorrected

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

Based on observation, record review, and interview the facility failed to ensure that qualified staff were to provide first aid and , ( ) and that staff were knowledgeable on ( ) requirements.

Findings included:

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Observation on at 9:00 am revealed Staff M working with the residents.

Record review revealed the facility hired Staff M on , and she completed her orientation (2 hours), and training on . Further record review revealed that the facility provided and First Aid training to facility staff on .

Interview on at 9:11 am Staff M stated, "I have only two days working here, I started to work . I work from 6:00 am - 9:00 am; I assist residents with their bath and breakfast. I had the training here in the facility, and I know how to do . If I found a resident unresponsive I will take the , ; I will advise to call 911, and I will start , . I have to do 30 , and 15 , . I will put the resident facing up, on the floor. I will call the administrator, and I will write a report. I do not still do not know who is under or risk."

Interview on at 9:27 am Staff E stated, "I have five month working in the facility, and I work 6:00 am - 1:00 pm. I clean the facility, change the bed and everything that concern with cleanness. I help with lunchtime feeding hospice's residents. I change residents' brief, clean the eating area, through away the garbage. The facility provided the . I am confident that I know what to do. For example, if I see a resident unresponsive, I will check the environment to make sure that he is on a safe place. Then, I touch his carotid (she touch her) to see if he has , , and I will advise the closest worker to call 911. If the resident is breathing, I do not have to do ; however, if the resident is not breathing I will do 30 , and 2 , . I also will follow the Rescue recommendations by phone.

Interview on at 9:43 am Staff B stated, "My duties are to provide care, bath, and medication, serving in lunch, snacks and activities. I had the training. If we have a resident unresponsive, I will check the place first and call for support. Then, I will put my on the to feel the and the under the to feel , . We will call 911, and the Rescue will tell me what to do, too. However, I know we have to put the on his and starts 30 , and two , .

Interview on at 10:00 am Staff H stated, "I am the cook, and my shift is from 8:00 am - 5:00 pm. I had the training. In case of an unresponsive resident, I will call him for his name, will first check the area, I put the resident on the floor, and call for help. Then, I will check for vital sign, if the resident is not breathing, I will call 911 with my cell phone, and I will start 30 , and 2 , . If the resident is breathing, I do not have to do . The facility put bracelet to residents with any special condition.

Interview on at 2:30 pm Staff A and G stated that they provided training to staff for . We

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classify residents with bracelets of three colors such as, red for elopement, yellow for risk and white for .

Class III