STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966548	**05/22/2019**
NAME OF PROVIDER OR SUPPLIER **HEAVENLY HOME CARE OF FLORIDA, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **17321 SW 109 AVENUE MIAMI, FL 33157**	

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

0000 - Initial Comments

A Re-licensure and Complaint Survey (complaint number 2019004499) was conducted on , , through , , . Deficiencies were identified at the time of survey.

0026 - Resident Care - Social & Leisure Activities - 58A-5.0182(2) FAC

Based on observation, record review, and interview the facility failed to conduct scheduled activities and offer / encourage the residents to participate in social, recreational, educational and other activities within the facility and the community.

Findings included:

Observations on at 8:00 AM during the tour found the activities calendar posted on the wall of the common area. The calendar for , , showed:

Morning to 10:00 AM, Grooming, breakfast; clean rooms.
From 10:00 AM to Noon, Board games.
From 12:00 PM to 2:00 PM, Lunch, Relax (Time to relax, sleep or watch TV)
From 2:00 PM to 3:00 PM, Reading by attendant.
From 3:00 PM to 5:00 PM, Afternoon walks in the neighborhood.
From 5:00 PM to 9:00 PM, Movie.

Further observations showed most residents left to local programs; only one resident observed at the facility in the morning. Later as residents came , they were observed until 3:30 PM sitting in their rooms or in the common area watching television.

On , , at 8:20 AM, Resident 3 stated that sometimes she would volunteer to take the garbage out and sometimes they would ask her to do it.

On , , at 8:35 AM, Resident 1 stated he without to the stores all the time and that did not participate in any local program.

On , , at 8:45 AM, Resident 4 stated that she watched TV sometimes and that she only slept, took medications and ate.

On , , at 9:10 AM, Resident 2 stated that sometimes they played dominos.

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Class III

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

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation and interview, the facility failed to provide available snacks for all residents after regular hours. All residents did not have access to any foods at night and the kitchen and refrigerator were kept locked.

Findings included:

On at 7:15 AM, observed a locked gate on the kitchen towards going to the resident's area. and a locked refrigerator located in the dining room. The administrator stated that she locked the gate at night when her children go to sleep. At 7:50 AM, the administrator said that the residents would call her and she would get up and open the refrigerator, "I have to lock it because one of the residents opened it and took the frozen food and tried to consume it raw, so I had to lock it."

On at 8:45 AM, Resident 4 stated, "If I need something, I will call her and she will give me snacks." When asked if they left snacks outside for them to take, "No but we would have more roaches."

On at 9:10 AM, Resident 2 stated, "I call at night if I need anything like milk; I do not have access to the kitchen."

Class III

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

Based on observation and interview, the facility failed to ensure that furniture were maintained in good working order and failed to provide a clean environment to all residents.

Findings included:

On at 7:15 AM, smelled a bad odor when entering the facility. During the tour, observed

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room for Residents 1 and 5 with trash on the floor, beds unorganized and a broken drawer; Staff B stated that Resident 5 who was at the hospital due to behavior issues had broken most of the walls and furniture at the facility. When Staff B was asked why there were 3 beds inside the room, he stated they replaced the bed for the resident at the hospital and the resident refused to allow the facility to take the old bed away. At the living room, where the residents washed TV, observed a live roach on the floor. The residents did not acted surprised and stated that it happened all the time. On the room for Resident 2, a big area floor carpet covered the room; underneath, the floor tiles were all cracked. The resident stated that it was like that for a while now.

On , at 8:15 AM, in reference to Resident 1, the Administrator stated, "He does not want to follow instructions; there is always a struggle with his hygiene. Eventually he will do it; he has a natural odor, he takes a bath but he smells; he walks a lot. We do the best we can."

On , at 8:20 AM, Resident 3 stated that sometimes she would volunteer to take the garbage and sometimes they would ask her.

On , at 8:45 AM, Resident 4 stated to see lots of roaches at the facility and when she would tell the staff, they spray. She added, "They have people who come to clean every other day. I see more roaches at night. The floor has been cracked since last year."

On , at 9:10 AM, Resident 2 stated that there was a woman who would go to the facility to clean and that she has seen roaches in the bathroom or if they leave the doors open and said, "They are big."

During the survey, observed the administrator and Staff B cleaning the floors and taking trash bags to the outside.

On , at 3:05 PM, the administrator and Staff B acknowledged that the floor was cracked and needed repair.

Class III

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

Based on record review and interview, the facility failed to verify that money received directly to the facility for one of five sampled residents, (Resident 5), had documentation on records showing accurate

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disbursement to the resident. The facility also failed to have a current physician's order for the use of half ( ) bed rails for one of five sampled residents, (Resident 1).

Findings included:

1) Review of the facility's ( ) disbursement log showed Resident 5 signed from to for $54.00 received each month.

On at 10:43 AM, the Administrator stated, "Resident 5 did get his this month ( ). I always try for them to sign at the same moment we give it to them. It was my mistake this month for him, I was not here; my husband gave him the money the day before he went to the hospital. He just left yesterday."

2) On at 7:30 AM, observed Resident 1's bed with bed rails.

Review of Resident 1's record did not have a prescription for the rails from the resident's physician.

On at 2:00 PM, the Administrator stated, "Resident 1 has the same bed he had before. It has rails because that is the way it came."

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(&) FS; 58A-5.0241 FAC

Based on observation, record review and interview, the facility failed to report within 1 business day after the occurrence of the adverse incident and a full report within 15 days to the agency including the results of the facility's investigations into the adverse incident for one of five sampled residents (Resident 5). Resident was from the facility and taken to the hospital.

Findings included:

On at 7:30 AM, observed an empty bed in a shared room with Resident 1. Staff B stated that the bed belonged to Resident 5 who had to be recently. According to Staff B, the resident was taken to the hospital by the police; he got aggressive and they called them and that he was at the hospital due to behavior issues, had broken most of the walls and furniture at the facility and the police had to be called many times.

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Review of Resident 5's record showed documentation stating that on the resident was cursing and swearing and refusing to take his medications and was eating frozen food that he took from the freezer. He was aggressive and arguing with other residents, slamming doors, not cooperating. The facility arranged transportation to pick him up.

Review of incident reports in the system, the facility did not have a report in reference to the incident. On at 4:45 PM, the Administrator stated that Resident 5 was not involuntarily taken by police or ambulance under and that is why the facility did not report it.

Review of the hospital record showed the resident's admission date . 'Admitted under by PC (primary care) from Assisted Living Facility (ALF) on at 7:30 pm. According to the patient, he was and . General appearance . Chief complaint, "I am bad". He has a long history of mental illness, well known to these services due to previous admissions and outpatient treatment at the ALF. According to the owner of the ALF, the patient was refusing to take his medications, aggressive, violent and . During the interview, the patient is grossly disorganized, talking to self actively responding to internal stimuli, , labile, jumping from one topic to another topic, disheveled with strong bad odor. Medical diagnosis: Brief .'

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation, record review and interview, the facility failed to maintain the minimum fuel required at the facility to be used with the alternative power source (Generator). The facility also failed to provide a monoxide detector inside the facility, provide policy and procedures and notify all residents or representatives of the compliance with the emergency power plan.

Findings included:

On at 7:30 AM, observed on the shed located in the outside patio, a portable dual generator for gasoline and propane gas. The facility did not have any fuel available. Inside the facility there was no monoxide detector installed.

Review of the facility's emergency plan records showed no policies and procedures.

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Review of all current resident records showed no documentation of notifications about the compliance with the emergency power plan.

On , , at 3:05 PM, the Administrator and Staff B acknowledged the lack of fuel, notice to residents and monoxide detectors.

Class III