Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968954	A. BUILDING: _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCES OF UNITED HOMECARE	9355 SW 158TH AVE MIAMI, FL 33196

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (complaint number 2019007247) was conducted at The Residences of United Homecare on and and concluded . Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=J	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel	A 025		

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A 025	Continued From page 1 independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the Assisted Living Facility failed to provide adequate supervision to ensure awareness of the general health, safety, and physical and emotional well-being of eight out of 44 sampled residents (#18, #11, #12, #13, #10, #16, #14, #15). Residents acquired multiple injuries, , and hospitalizations resulting from multiple . The facility also failed to implement sufficient preventive actions to decrease or eliminate continuous . Findings included: 1.During the facility tour on at 8:52 AM, a loud noise was heard coming from Resident #18's room. On at 8:53 AM, Resident #18 was observed lying on the floor facing up next to the wall with coffee spilled all over the resident and the floor. On at 12:06 PM, Registered Nurse (RN) B revealed Resident #18 had a history of .	A 025		

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A 025	Continued From page 2 She further stated that the resident had multiple times and there was a care plan meeting scheduled with the family for the following day, but the resident's family cancelled. Nurse B stated that the meeting was planned to discuss a possible discharge since the resident continued to because she was not following instructions given by the facility. Nurse B said Resident #18 went out with her daughter the day before, and when the resident returned, her daughter told staff that her mother did not have a steady gait. On at 12:11 PM, Nurse A revealed that the resident had three times since . Review of Resident #18's record showed a health assessment completed on , which showed a medical history and diagnoses of , , , , , , ( ), and a status post (medical device that relieves pressure on the caused by fluid accumulation). The assessment showed the resident needed and precautions. An admission summary completed on revealed the resident had a history of frequent at her previous assisted living facility. The resident had a VP (,) placement procedure done on . Further review of progress notes for Resident #18 showed that on a staff member heard a request from Resident #18's bathroom for assistance. the staff member found the resident sitting on the bathroom floor with a small red discoloration to the left . A note dated at 10:30 AM, stated that the resident was still hospitalized since the .	A 025		

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A 025	Continued From page 3 Review of hospital records in Resident #18's file showed that she had a CT without contrast completed on which showed that Resident #18 suffered an acute left frontal hematoma as well as a left-sided hematoma. The hospital had transferred the resident to a different hospital. The discharge diagnoses on included hematoma, acute hematoma, injury of and . According to the Mayo Clinic database, a hematoma is when between the and the outermost layer of the three layers that cover the (dura mater). The hematoma is when a between the outer surface layer of the dura mater and the . The then leaks between the dura mater and the to form a that presses on tissue. The controls the communication between the and the . Further review of hospital discharge documents showed that Resident #18's reason for visit included a " injury " and the discharge diagnoses on were , and . The hospital records explained that the was the in the area between the and the that covered the ; this caused pressure on the and can deprive some areas of the of flood. can cause permanent damage, or even . A CT without contrast scan was completed on and showed that the resident had an acute left frontal hematoma as well as a left-sided	A 025		

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A 025	Continued From page 4 hematoma; both hematomas were found on . Review of progress notes for Resident #18 showed that there was a note dated . . . . . indicating that on the resident did not feel well while out on pass and her daughter took her to the hospital. On , the night shift reported that the resident continued ambulating without an assistance device and had problems falling sleeping. There was no documentation of any ; there was only a note that the facility had sent the resident to the hospital because she was more than usual, had generalized . . . . . , and . . . . . . An additional review of hospital records in Resident #18's record showed that the reason for visit included " . . . injury . . " and the discharge diagnoses on included acute . . . . . , abnormal . . . . . and . . . An interview with Resident # 18's daughter on . . . . . at 1:25pm revealed that Resident # 18 had a of the and continued to be a bit disoriented from the on . . . . The daughter stated Resident # 18's biggest was on . . . . . because her mother suffered from two bleeds. The daughter also stated that Resident # 18 had . . . around . . times at the facility and all the facility did was tell her to use the call light if she had to move, use her walker, and/or wait for the nurse. Additionally, the daughter stated "the facility told me that my mother can't go . . . there, so I'm looking for a smaller facility. I just feel bad because she's already accustomed to the facility and when she changed from the other facility, she lost . . , ... I told them about her history of , and they told her that they'll make	A 025		

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A 025	Continued From page 5 sure that she uses her walker". 2. Review of Resident #11's record showed that there was a health assessment (AHCA form 1823) completed on which identified her with precautions and wheelchair-bound, non-ambulatory and required total care for ambulation. Review of a discharge summary from a visit to urgent care center on showed that Resident #11 , which resulted in a of the right and a . Review of a hospital discharge summary showed that the resident on resulting in multiple of the left upper extremities and , acute , , and loss of balance. An interview with Resident #11's son on at 10:32am revealed that his mother is not in hospice care and the facility had not contacted him to place any type of intervention for Resident # 11. 3. Review of Resident #12's record showed that the health assessment completed on indicated that she had a medical history and diagnoses of a aneurysm, , , and . She was and and needed supervision with ambulation, bathing, , self-care, toileting and transferring. It did not show that the resident needed any special precautions. A previous health assessment completed on indicated that the resident had , mobility related to advance and in the lower . She needed precautions and assistance for ambulation, , eating, self-care, toileting and	A 025		

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A 025	Continued From page 6 transferring. Review of Resident #12's discharge instructions from a hospitalization on showed the discharge diagnoses were of the , and unwitnessed . The reason for visit was 'closed injury without loss of and with '. The CT without contrast completed on showed left and left forehead , and . An interview with Resident #12's daughter on at 10:24 pm revealed that the facility had contacted her when her mother was found in the bathroom facing up and told her that she had hit her , but she did not know with what she had hit her with. The daughter stated that the facility told her that they did not know if Resident #12 first then moved; however, they called rescue and transported her to the hospital. The daughter also stated that her mother had only hit her and was . She also stated that she believed her mother had before, but she did not recall the date. 4. Review of Resident # 13's record showed that there was a health assessment completed on . The health assessment indicated that the resident had medical history and diagnoses of type II , and , . It also showed that she had difficulty ambulating due to of the , , and , . The resident needed precautions, supervision for ambulation, , toileting, and transferring; however, required assistance with bathing. Review of the resident's record showed that she at the	A 025		

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A 025	Continued From page 7 facility on [illegible] and [illegible]. Review of discharge instructions from the hospital on [illegible] found in Resident #13's file showed that the reason for the visit included [illegible], [illegible] and [illegible]. She received a final diagnosis of acute [illegible] of the left [illegible] due to [illegible]. Review of discharge instructions from the hospital on [illegible] found in Resident #13's file showed that the reason for the visit included [illegible], and arm [illegible]. She received a final diagnosis of acute [illegible] of the right [illegible] and arm, [illegible] and [illegible]. Review of discharge instructions from the hospital on [illegible] found in Resident #13's file showed that the reason for the visit included [illegible] and arm [illegible] and [illegible]. She received a final diagnosis of accidental [illegible] and acute [illegible]. 5. Review of Resident #10's record showed that there was a health assessment completed on [illegible]. The health assessment indicated that he had a medical history and diagnoses which included atherosclerotic [illegible], prostatic hyperplasia without lower [illegible] tract symptoms, [illegible] without loss of [illegible], difficulty walking, history of [illegible], [illegible], and [illegible]. It also indicated that he required assistance with all types of activities of daily living and skin and precautions. Documentation in the record showed that he [illegible] in the facility at least on four different occasions ([illegible], and [illegible]). Review of discharge instructions found in	A 025		

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A 025	Continued From page 8 Resident #10's file revealed his discharge date from the hospital was on . The final diagnoses were and to the right while the reason for visiting was and . Review of discharge instructions found in Resident #10's file revealed his discharge date from the hospital was on . The final diagnoses, included as the reason for the visit, were injury-minor, , and . Review of the resident's record showed that on the resident went to the nurse station around 7:00 AM and informed that he from the bed around 4:00 AM. The resident did not inform the facility. The resident went to bed after the . He complained of on the left and right / area. Review of transfer/discharge report found in Resident #10's file revealed the resident was in a rehabilitation facility from to . The list of diagnoses provided by the facility included: atherosclerotic of native , without pectoris, concussion without loss of subsequent encounter, difficulty walking, history of falling, , unspecified , prostatic hyperplasia without lower tract symptoms, , essential , , without loss of , and unspecified without behavioral disturbance. Review of discharge instructions found in Resident #10's file revealed his discharge date	A 025		

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A 025	Continued From page 9 from the hospital was on . . . . The final diagnoses were closed injury and while the reason for visiting were . . . . . closed injury without loss of . . . . . and " . . . . injury". Review of progress note completed on . . . . . showed that Resident #10 when attempted to get up from the wheelchair and hit the . . . of his . A later entrance showed that the resident returned from the hospital status post . . . Review of discharge instructions found in Resident #10's file revealed his discharge date from the hospital was on . . . . . The final diagnoses were and injury while the reason for visiting was . . . The hospital completed Ct without contrast and . . . ; they did not show any new abnormalities. Review of Resident #10's record showed on , staff found the resident sitting on the floor next to his bed. The resident complained to the staff about feeling very weak, attempted to use the bathroom and had generalized . . . . The facility sent him to the hospital 20 minutes later. On . . . . . showed that the facility contacted the resident's son and notified him that his father did not meet the criteria for being readmitted to the facility. His father had multiple with injuries and . . . . . and functional decline. The facility completed the last progress note on . . . . . The progress note showed "As per facility's administrator, resident has been discharged immediately due to high risk for injury due to safety concerns." The resident's family took him to a small facility where he can receive one to one supervision. An interview with Resident # 10's daughter on	A 025		

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A 025	Continued From page 10 at 10:45am revealed that the daughter stated "They're not allowing him to live there anymore because he quite a bit. His are very weak and kept on falling at home. He's around 8 times and the facility has talked to him and told him that he had to stay in his wheelchair and use the call button if he needs something. I had a meeting with the directors, but no interventions were taken in place other than the call button. They told him that he couldn't get up without calling one of the CNA's (Certified Nursing Assistant). One time he and hit his . He had surgery because he had liquid on the left side of his . This was on and he was readmitted to the facility on . After surgery, he went to and rehab. After rehab, he started to use his wheelchair". 6. Review of Resident # 16's records showed a health assessment was completed on . The health assessment revealed precautions, forgetful at times, unsteady gait/ , and was diagnosed with the following: Non- Lymphoma, , and . Resident # 16 was independent while eating and required supervision with Self Care (grooming); however, required assistance with ambulation (wheelchair & rolling walker at times), bathing, , toileting, and transferring. Review of discharge instructions found in Resident #16's file revealed he was discharged from the hospital on . The 'reason for visit' stated injury, , and . Resident # 16's final diagnosis were concussion, , and a of the left . Review of progress notes dated revealed "resident was found on the floor next to his bed	A 025		

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A 025	Continued From page 11 next to nightstand. [illegible] to right side [illegible] noted. Cleaned with water and [illegible] dry." The notes also stated that the resident did not want to be taken to the hospital and the daughter agreed. Further review of progress notes dated [illegible] stated that resident returned from local hospital with a diagnosis of [illegible] injury, [illegible] concussion and [illegible] of the left [illegible]. Further review of Resident # 16's records revealed a set of documents labeled Care Plan Meeting dated [illegible]. The document stated, "Today's care plan was due to residents change in functional status, refusal to call for assistance, frequent [illegible] and unsafe transfers". The document also stated, "If resident continues to [illegible], resident will be given a 45 day notice for discharge unless resident is in immediate danger, then resident will be transferred to a safer facility". 7. Review of Resident #14's records showed a health assessment completed on [illegible]. The health assessment stated that he was diagnosed with [illegible] ([illegible]), [illegible] with [illegible] ([illegible]), [illegible] on [illegible], and [illegible]. He required supervision in bathing and [illegible], and was independent in ambulation (uses a rolling walker), eating, self-care, toileting, and transferring. Resident #14 did not have any special precautions listed; however, his health assessment stated no strenuous exercise or efforts. Additionally, Resident #14 has been undergoing [illegible] treatment three times a week. Review of progress notes stated that resident was found lying on the bathroom floor next to the	A 025		

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A 025	Continued From page 12 toilet. A few hours later, the resident started to complaint of , to the right , and was transferred to the hospital. Hospital discharge documents stated that Resident # 14 suffered a (...) to the right , . 8. Review of Resident # 15's records showed a health assessment completed on . The health assessment stated that she was diagnosed with , , , , and had a history of . The health assessment also stated that she had no special precautions and was independent for all activities of daily living. Review of Resident # 15's progress notes revealed an entry on at 5AM stating that a CNA heard a voice coming from the resident's room and upon entering the room, the resident was found on the floor at 12:50am in supine position complaining of , to the right , and was unable to move. Review of case manager notes revealed a note from that stated resident was found on on the bathroom floor and complaining of , in the right , and was transferred to the hospital. Resident # 15's daughter had told the case manager that Resident # 15 her , and case manager recommended for the resident to go to a rehab for , once discharged from the hospital. Further review revealed an additional case manager note dated at 9am which stated that Resident # 15's daughter informed the facility that Resident # 15 received , surgery on . Class I	A 025		

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A 030 SS=D	58A-5.0182(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 58A-5.0182 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 58A-5.0181, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 58A-5.0181, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:	A 030		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCES OF UNITED HOMECARE	9355 SW 158TH AVE MIAMI, FL 33196

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 14 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical .	A 030		

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A 030	Continued From page 15 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both	A 030		

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A 030	Continued From page 16 are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , , , , , , , , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff	A 030		

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A 030	Continued From page 17 of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident ' s access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27(1)(a), FS	A 030		

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A 030	Continued From page 18 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the Assisted Living Facility (ALF) failed to keep resident's information confidential for 25 out of 44 sampled residents. Findings included: 1. On at 7:56 AM, there was a paper labeled " LIST" (List) in the dining room. The list revealed the names and room numbers for Residents #1, 3, 8, 20, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, and 45. On at 8:20 AM, Registered Nurse (RN) B revealed that a leaf on the resident's door meant at risk for , a car meant elopement risk,	A 030		

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A 030	Continued From page 19 a cup meant . , ... precaution and a butterfly meant that the resident had a . . . . in place. On . . . . . at 2:43 PM, RN A revealed that the facility used symbols at the door of the resident's room for confidentiality reasons. She stated that the facility did not want to break the HIPAA law. She also stated that the . . . list in the dining room was supposed to have a blank paper covering the information. Class III	A 030		
A 055 SS=D	58A-5.0185(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for	A 055		

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A 055	Continued From page 20	A 055		

whom it is prescribed;
4. The resident fails to maintain the medication in a safe manner as described in this paragraph;
5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or
6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 58A-5.0181, F.A.C.
(c) Centrally stored medications must be:
1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times;
2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked;
3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and,
4. Kept separately from the medications of other residents and properly closed or sealed.
(d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it

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A 055	Continued From page 21 is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the Assisted Living Facility failed to keep medications locked at all times for one out of 44 sampled resident (#9). Findings included: On at 7:01 AM, there was a medication bottle with Resident #9's name in # . The medication bottled had a prescription labeled 300 mg capsule and instructions to take one capsule every day at bedtime. According to Mayo Clinic is a medication	A 055		

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A 055	Continued From page 22 used to treat mild to moderate , .	A 055		
	On . . . . . at 7:02 AM, Staff A revealed that Resident #9 was out the day before with the family. The resident did not return the medication to staff when she returned to the facility. Review of Resident #9's record showed that there was a health assessment (AHCA form 1823) completed on indicating that the resident needed assistance with self-administration of medications and she may have . . (Over the Counter) at bedside and self-administer. Class III			
A 093 SS=D	58A-5.020(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met	A 093		

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A 093	Continued From page 23 by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and	A 093		

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A 093	Continued From page 24	A 093		

served as ordered by the health care provider.
1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility.
2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal.
(f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of , the time between meals.
(g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on .
(h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water

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A 093	Continued From page 25 sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the Assisted Living Facility (ALF) failed to have a menu dated and planned at least one week in advance for both regular and therapeutic diets. The ALF failed to ensure that a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist documented the annual review of all regular and therapeutic menus and included the original signature of the reviewer and date reviewed. Findings included: On at 7:33 AM, the ALF had individual menus at the entrance of the dining room. It included the menu for lunch on and the alternative options. There was another menu that showed a breakfast menu; however, did not show the date. The ALF displaced the weekly menu on electronic boards throughout the facility. On at 8:18 AM, the electronic board on the second floor showed the menu for week 5. The top part of the menu showed the days of the week as "Day 29" to "Day 35". It did not show the reviewed date and the reviewer signature. When the screen passed, a second screen showed the menu for lunch on .	A 093		

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A 093	Continued From page 26 Furthermore, the posted menu was only posted in English. Review of menus provided by the Director of Kitchen Dining Services on at 9:17 AM showed that they covered weeks 1, 2, 3, and 4. The menus did not include the portion sizes or the date the menus were reviewed. On at 9:19 AM, the Director of Kitchen Dining Services revealed the menus he had were the current menus. He stated that there was a problem with the electronic boards. Class III	A 093		
A 162 SS=D	58A-5.024(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name; 2. ; 3. Race; 4. Date of birth; 5. Place of birth, if known; 6. Social security number; 7. Medicaid and/or Medicare number, or name of other health insurance ; 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in Rule	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968954	A. BUILDING: _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCES OF UNITED HOMECARE	9355 SW 158TH AVE MIAMI, FL 33196

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 162	Continued From page 27 58A-5.0181, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, [illegible], or other services to be provided, supervised, or implemented by the facility that require a health care provider ' s order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 58A-5.020, F.A.C., if applicable. (e) The resident care record described in paragraph 58A-5.0182(1)(e), F.A.C. (f) A ⌄ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ⌄ recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 58A-5.025, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968954	A. BUILDING: _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCES OF UNITED HOMECARE	9355 SW 158TH AVE MIAMI, FL 33196

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 162	Continued From page 28 written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an . . . recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , ... , , ( ), CF-ES 1006, . . . , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 58A-5.0181, F.A.C. (o) The resident ' s , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement; 2. The resident demographic data required in this paragraph; 3. The health assessment described in Rule 58A-5.0181, F.A.C.; 4. The resident's contract described in Rule	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968954	A. BUILDING: _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCES OF UNITED HOMECARE	9355 SW 158TH AVE MIAMI, FL 33196

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 162	Continued From page 29 58A-5.025, F.A.C.; and 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Assisted Living Facility failed to have completed health assessment for two out of 44 sampled residents (#1 and 13). The facility failed to have an health assessment that reflected the change in condition for one out of 44 sampled residents (Resident # 5) Findings included: 1. Review of Resident #1's record showed that there was a health assessment completed on . . . . . . The health assessment did not have the name of the examiner. Review of Resident # 13's record showed that there was a health assessment completed on . The health assessment did not indicate that the facility can met the resident's needs.	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 162	Continued From page 30 2. Review of Resident #5's records showed that there was a health assessment completed on [redacted]. The health assessment stated under Additional Comments " is NOT for feeding, was for surgery. Do not need to manipulate". Further review of the health assessment showed that under Special Precautions it stated, "Surgical procedure that was performed does not require any care to site. Not to be touched by staff. Patient will follow-up with surgeon". According to the American Society of Endoscopy, mean [redacted]. The was a flexible placed through the wall and into the . It was used for giving nutrition, fluids and/or medications directly into the [redacted] the and . On at 11:01 AM, RN A revealed that Resident #5 no longer had the . On at 11:06 AM, Resident #5 did not have any . She had a healed on the left upper quadrant of the abdomen that looked like she had a in place. Class III	A 162		