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
	AL11966148	A. BUILDING: _____ B. WING _____	R 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIME IS CARE	19010 NW 44 AVENUE OPA LOCKA, FL 33055

(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 revisit to a re-licensure survey was conducted at Time is Care on [redacted] through [redacted]. Deficiencies were identified at the time of the survey.	{A 000}		
A 010 SS=G	429.26(1&9) FS; 58A-5.0181(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (9) A [redacted] ill resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of	A 010		

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A 010	Continued From page 1 the resident are being met. 58A-5.0181 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from the facility. (c) A ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions	A 010		

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A 010	Continued From page 2 are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the appropriateness of continued residency for one out of two sampled residents (Resident # 1).	A 010		

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A 010	Continued From page 3 Findings included: On . . . . . at 7:30am, observed Resident # 1 in the living room with an ( ) site covered in a . . . . ˬ around her left upper arm. A review of Resident # 1's records revealed a progress note dated that stated 'Resident was sent to hospital around 10:30am. She is not feeling well, , on both ˬ and . . . . '. A second progress note dated . . . . stated 'Resident returned around 4:40pm stable came . . . with home health . . . . . by . for 10 days. Further review of Resident # 1's records showed a discharge summary from the hospital with discharge instructions that stated 'Home Health Care (HHC) for Registered Nurse (RN) evaluation and to administer (Invanz 1 g daily x 10 days)' A review of Resident # 1's hospital records revealed Resident # 1 arrived to the hospital on . . . . . due to . . . . . and was diagnosed with Acute Hypoxic Hypercapnic . . , . . . , Failure and a . . . , ... ( ) for ( ). Further review of hospital records revealed she was placed in an isolation room due to the and had a . . , ... ( ) Line placed to receive . Furthermore, Resident # 1 was then moved to a stepdown unit to continue receiving . Additional hospital records showed that Resident # 1 was discharged on with Home Health Care instructions to receive . . . . . every 24 hours for 10 days via line at the facility. A review of the facility's license on Florida Health Finder revealed the facility was issued a standard license effective and expires on .	A 010		

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A 010	Continued From page 4 The facility was never issued a limited nursing services (LNS) or an extended congregate care (ECC) license. On at 10:27am, the Administrator stated that Resident # 1 returned to the facility from the hospital on with discharge instructions to have a registered nurse from a Home Health Agency administer to Resident # 1 for the next 10 days at the facility. The Administrator also stated that she did not know she was unable to have Resident # 1 at the facility and had explained to her staff to not touch the resident's site. Class II	A 010		
{A 027} SS=D	58A-5.0182(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making and remind residents about scheduled for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a health care provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to assist two out of two residents with	{A 027}		

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{A 027}	Continued From page 5 arrangements for health care services (Resident # 1 and # 2) after being sent to the hospital. Resident # 1 had not received a follow-up visit from a Primary Care Physician (PCP) until 11 days after being discharged from the hospital. In addition, Resident # 2 also had not received a follow-up visit from his PCP until 17 days after being discharged. Findings included: A review of Resident # 1's records revealed a progress note dated [redacted] which stated 'Resident was sent to hospital around 10:30am. She is not feeling well, [redacted] on both [redacted] and [redacted]'. A second progress note dated [redacted] stated 'Resident returned around 4:40pm stable came [redacted] with home health [redacted] by [redacted] for 10 days. Further review of Resident # 1's records showed a discharge summary from the hospital with discharge instructions that stated 'Home Health Care (HHC) for Registered Nurse (RN) evaluation and to administer [redacted] (Invanz 1 g [redacted] daily x 10 days)'. In addition, the discharge instructions contained follow-up instructions to follow-up with a Primary Care Physician (PCP) within 5 - 7 days. A review of Resident # 2's records revealed a progress note dated [redacted] which stated the resident was complaining of [redacted] and felt [redacted]. The ambulance was called, and the resident was sent to the hospital around 7:45pm. Resident # 2 was discharged and returned to the facility on [redacted]. On [redacted] at 10:36am, the Administrator stated that both Resident # 1 and # 2 had an [redacted] with the facility's PCP sometime this week; however, was waiting to hear from	{A 027}		

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{A 027}	Continued From page 6 the doctor's office. On . . . . . at approximately 1:50pm, the Administrator stated that the facility's PCP had just visited Resident # 1 and Resident # 2. Class III Uncorrected	{A 027}		
{A 054} SS=D	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known ___ the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical	{A 054}		

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{A 054}	Continued From page 7 ..., the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to immediately update the Medication Observation Records (MOR) each time the medication is offered when assisting one out of two (Resident's # 2) sampled residents with self administration of medication. Findings included: A review of Resident # 2's MOR revealed medication ... - 10mg was scheduled at 8 PM and was not initialed as given on . Further review of the MOR revealed that medication ... - 75 mg was initialed as the medication was given on .... A medication reconciliation showed that medication ... - 10 mg and Clopidrogel - 75 mg were missing 18 pills each from their packs which showed that ... - 10 mg was given to the resident and Clopidrogel - 75 mg has not. On at 7:31 am, Staff B stated that she did not know what happened and forgot to sign last night's medication and must have been documenting incorrectly for the Clopidrogel - 75 mg. Class III Uncorrected	{A 054}		

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CZ824 SS=C	408.811 FS; 59A-35.120 FAC Right of Inspection; Inspection Reports 408.811 Right of inspection; copies; inspection reports; plan for correction of deficiencies.- (1) An authorized officer or employee of the agency may make or cause to be made any inspection or investigation deemed necessary by the agency to determine the state of compliance with this part, authorizing statutes, and applicable rules. The right of inspection extends to any business that the agency has reason to believe is being operated as a provider without a license, but inspection of any business suspected of being operated without the appropriate license may not be made without the permission of the owner or person in charge unless a warrant is first obtained from a circuit court. Any application for a license issued under this part, authorizing statutes, or applicable rules constitutes permission for an appropriate inspection to verify the information submitted on or in connection with the application. (a) All inspections shall be unannounced, except as specified in s. 408.806. (b) Inspections for relicensure shall be conducted biennially unless otherwise specified by authorizing statutes or applicable rules. (2) Inspections conducted in conjunction with certification, comparable licensure requirements, or a recognized or approved accreditation organization may be accepted in lieu of a complete licensure inspection. However, a licensure inspection may also be conducted to review any licensure requirements that are not also requirements for certification. (3) The agency shall have access to and the licensee shall provide, or if requested send, copies of all provider records required during an inspection or other review at no cost to the agency, including records requested during an	CZ824		

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CZ824	Continued From page 1 offsite review. (4) A deficiency must be corrected within 30 calendar days after the provider is notified of inspection results unless an alternative timeframe is required or approved by the agency. (5) The agency may require an applicant or licensee to submit a plan of correction for deficiencies. If required, the plan of correction must be filed with the agency within 10 calendar days after notification unless an alternative timeframe is required. (6)(a) Each licensee shall maintain as public information, available upon request, records of all inspection reports pertaining to that provider that have been filed by the agency unless those reports are exempt from or contain information that is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution or is otherwise made confidential by law. Copies of such reports shall be retained in the records of the provider for at least 3 years following the date the reports are filed and issued, regardless of a change of ownership. (b) A licensee shall, upon the request of any person who has completed a written application with intent to be admitted by such provider, any person who is a client of such provider, or any relative, spouse, or guardian of any such person, furnish to the requester a copy of the last inspection report pertaining to the licensed provider that was issued by the agency or by an accrediting organization if such report is used in lieu of a licensure inspection. 59A-35.120 Inspections. (1) When regulatory violations are identified by the Agency: (a) Deficiencies must be corrected within 30 days of the date the Agency sends the deficiency	CZ824		

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CZ824	Continued From page 2 notice to the provider, unless an alternative timeframe is required or approved by the Agency. (b) The Agency may conduct an unannounced follow-up inspection or off-site review to verify correction of deficiencies at any time. (2) If an inspection is completed through off-site record review, any records requested by the Agency in conjunction with the review, must be received within 7 days of request and provided at no cost to the Agency. Each licensee shall maintain the records including medical and treatment records of a client and provide access to the Agency. (3) Providers that are exempt from Agency inspections due to accreditation oversight as prescribed in authorizing statutes must provide: (a) Documentation from the accrediting agency including the name of the accrediting agency, the beginning and expiration dates of the provider's accreditation, accreditation status and type must be submitted at the time of license application, or within 21 days of accreditation. (b) Documentation of each accreditation inspection including the accreditation organization's report of findings, the provider's response and the final determination must be submitted within 21 days of final determination or the provider is no longer exempt from Agency inspection. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure their deficient practices were corrected within 30 days after being notified of them by the Agency for Health Care Administration (AHCA).	CZ824		

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CZ824	Continued From page 3 Findings included: A review of the facility's history of surveys revealed that from through , the facility failed to assist a resident with a follow-up , , with their Primary Care Physician (PCP) within 5 - 7 days from being discharged from the hospital and also failed to maintain an accurate Medication Observation Record (MOR) while assisting a resident with self-administration of medication. On . . . . through . . . . . during a revisit, a review of Resident # 1's records showed a patient discharge summary from a local hospital instructing Resident # 1 to follow-up with a PCP within 5 - 7 days. Resident # 1 was discharged on . A review of Resident # 2's records showed Resident # 2 was discharged on . . . . . Both residents were seen by a PCP after more than 10 days from being discharged from the hospital. On at 10:36am, the Administrator stated that both Residents # 1 and # 2 had an , , with the facility's PCP sometime this week; however, was waiting to hear . . . from the doctor's office. On at approximately 1:50pm, the Administrator stated that the facility's PCP had just visited Resident # 1 and Resident # 2. A review of Resident # 2 MOR revealed medication . . . . . - 10mg was scheduled at 8PM and was not initialed as given on . Further review of the MOR revealed that medication , . - 75mg was initialed as the medication was given on	CZ824		

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CZ824	Continued From page 4 A medication reconciliation showed that medication , - 10mg and Clopidrogel - 75mg were missing 18 pills each from their packs which showed that , - 10mg was given to the resident and Clopidrogel - 75mg has not. Unclassfied	CZ824		