STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968936	**08/21/2018**
NAME OF PROVIDER OR SUPPLIER **OASIS CENTER CARE CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **4023 SW 138 AVE** **MIAMI, FL 33175**	

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

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review and interview, the facility failed to maintain an updated employee roster in the Background Screening Clearinghouse Database.

Findings included:

A review of the facility's roster in the Background Screening Clearinghouse Database revealed Staff F hired on was listed on the facility's roster. A review of the facility's personnel file on revealed that Staff F, hired on , did not have a file to review.

During an interview on at 11:29 AM, the Administrator stated "Staff F had an emergency, Staff F left more than 15 days ago, so I hired someone else.""

Unclassified

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0000 - Initial Comments

A Complaint (CCR# 2018012206) Survey was conducted from and concluded on . Oasis Center Care Corp. with limited mental health component (license #12788) had deficiencies at the time of the survey.

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

Based on record review and interview, the facility failed to provide care and services appropriate to meet the needs of two out of 11 sampled residents (Residents #1 and #2). Resident #1 was found unresponsive in the facility, staff failed to perform ( ) and the resident . Resident #2, who required precautions, sustained multiple head from at the facility within two days. The facility also failed to maintain a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, or other changes that resulted in the provision of additional services for two out of 11 sampled residents (Resident #1 and #2).

Findings included:

1) During an interview on at 8:40 AM, Staff D stated that she saw Resident #1 at 6:00 am on , and she didn't look good. Staff D stated that the resident was out of bed, going to the , and her legs were criss crossed. Staff D asked the resident if she was ok, and the resident said 'Yeah, why?', so staff went back to bed. Staff D did not ask the resident if she needed medical care, and did not conduct further rounds until around 8:00 am, when she found Resident #1 . Staff D reported that she called the Administrator, who told her to call 911. Staff D stated that emergency medical services ( ) told her to begin ( ), so she put the resident on the floor, and then arrived.

A review of the ambulance run record on revealed the paramedics arrived at 8:13 am on . They were told that the resident was last seen alive at 11:00 pm the night before. The run record stated Resident #1's body was stiff, , and blue, and that the showed the resident as (no heartbeat).

A review of the facility's record on revealed that the facility's policies and procedures on the caretaker jobs summary stated, "Report changes in the resident's condition/needs immediately to the administrator where further instructions will be given. Maintain/complete records/reports in accordance with the facilities. 11:00 pm -7:00 am shift is required to conduct hourly rounds and bed checks to assure the comfort and safety of all residents. Assist any residents that require help." The facility was

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968936	08/21/2018
NAME OF PROVIDER OR SUPPLIER **OASIS CENTER CARE CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **4023 SW 138 AVE** **MIAMI, FL 33175**	

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

unable to provide documentation or demonstrate that hourly rounds or bed checks were completed by Staff D from 11:00 PM to 7:00 AM on .

During an interview on at 9:13 AM, the Administrator stated on "Resident #1 woke up. She went to the kitchen and then went back to bed. The employee went to call her to eat breakfast, she did not react she was rigid. The employee called me. I instructed her to call 911. The staff were instructed to call me and 911 at the same time, but when it is an emergency they have to call 911 first. It is not that they have to call both at the same time but when there is an emergency they have to call 911 first. She did not call 911 first this time. They shouldn't do it, but they did call the Administrator first. She got scared and called to say that the resident did not react and I told her to call 911 immediately. The staff did not perform and called 911 who told her to start . I did not instruct her to do ." Interview with the staff and the Administrator revealed that they did not know how to perform .

During an interview at 8:40 AM, Staff D stated "I give 30 compressions and mouth breathing. I don't know how many mouth and go back to compression. I do when somebody is not responsive and breathing."

During an interview on at 09:06 AM Staff B stated "I do to a resident who needs it, a resident that is in the necessity of I have to give it. I put the head up, I give 30 compression depending on what 911 says."

During an interview on at 9:13 AM, the Administrator stated "All staff received training. I am trained in . I do if a resident is not breathing, I take the heartbeat, and I do 7-8 compressions."

A review of Resident #1's file on revealed that there were no progress notes regarding the resident's health status and the resident's on . The facility also failed to have updated policy and procedures or documentation that staff received an updated training available for review after Resident #1 was found unresponsive on and staff failed to perform .

In an interview on at 10:28 am trainer confirmed staff received training from the facility. Further interview with the trainer revealed 30 compressions and 2 breaths, this should continue till arrives.

2) A review of Resident #2's health assessment dated revealed the resident did not have any medical history or diagnoses documented. However, the resident was receiving which is used to help relieve nerve pain (, , ,). is used to treat and prevent in the

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968936	08/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS CENTER CARE CORP	**4023 SW 138 AVE MIAMI, FL 33175**

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

stomach and intestines. , is used to treat , used to treat moderate to severe of the 's type. And used to treat , and . The resident needed supervision with ambulation, bathing, dressing, eating, , toileting and transferring. Resident #2 required precautions.

During an interview on at 11:29 AM, the Administrator stated Resident #2 on and went to the hospital but returned to the facility. She revealed Resident #2 was currently in the hospital because she was , and almost on .

A review of the progress notes dated stated "Hospitalized-unbalanced, off her bed and , admitted her at a hospital - return same day" "hospitalized - continues unbalance, her and admitted her another hospital." Record review revealed Resident #2, who had precautions, did not have any intervention in place to prevent the resident from having multiple that resulted in .

A review of the hospital records on revealed Resident #2 was admitted at the hospital on and the triage notes stated "patient at the facility with a big gash on the back of her head, LOC (loss of) and patient does not remember the . Assisted Living Facility mate found her on the floor after a slip and and was brought to the ED (emergency department) via ambulance."

A review of Resident #2's hospital records dated revealed "patient baseline presenting to ED via fire rescue from ALF after being found down after assumed GLF (ground level). Patient has laceration to R (right) scalp, as well as revised (staple) laceration to occipital scalp of unknown age. The diagnosis and assessment plan dated stated "Injuries: - Acute left hemispheric hematoma measuring up to 12 mm grade 3 (midline shift from left to right by 5 mm). - along the cerebra convexities and within the basilar cisterns grade 2. - Questionable in the left frontal grade 2. - of the , portion of the right , bone and the right coronal suture grade 2. - Right parietal bone grade 3 with , extending to orbital roof and greater wing of the sphenoid." The discharge summary dated stated "patient with Hx (history) of , brought from an ALF after have from the bed while sleeping. Person in charge of the ALF reports that patient down 3 days prior while attempting to reach the . At that time had an occipital scalp laceration and got repaired at OSH. Patient was found a new left , scalp laceration that was repaired by the ED team. CT revealed left holohemispheric Hematoma 12 mm with 5 mm midline shift. Neurosurgery was consulted and patient was started on , , anticoagulation held, non- , management. Repeat CT showed stable exam therefore no surgical intervention indicated. Right frontal and , bone were noted. Plastic was consulted and non- , management

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	AL11968936	08/21/2018
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

was deemed appropriate."

Class I

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on interview and record review the assisted living facility failed to record the assistance with self-administration of medications as required for 2 of 6 sampled residents (Residents #4 and #5).

Findings Included:

On , 2018, between 9:50 am - 10:30 am, in interviews with Residents #4 and #5 revealed they received their morning medications.

On , 2018 between 9:50 am - 10:30 am a review of the facility's medication observation records (MORs) revealed that the facility failed to sign the record at the time the medications were given or offered to the residents.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation, record review, and interview, the facility failed to discard medications that were abandoned within 30 days for four out of 11 sampled residents (#8, #9, #10, and #11) .

Findings included:

During the facility tour on at 6:59 AM three medications bags were found in a locked closet. Two of the three bags had and 0.5 mg and in a locked black box inside of the refrigerator was 25 mg .

During an interview on at 7:10 AM, Staff B pointed at the bags and stated "not here, not here."

A review of the facility admission and discharge book revealed Resident #8 was discharged on , Resident #9 was discharged on , Resident #10 was discharged on , and Resident # 11 was discharged on .

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968936	08/21/2018
NAME OF PROVIDER OR SUPPLIER **OASIS CENTER CARE CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **4023 SW 138 AVE** **MIAMI, FL 33175**	

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

0076 - ( ) - 58A-5.0186 FAC

Based on record review and interview, the facility failed to perform , , for one out of 11 sampled resident (Resident #1) who did not have a ( ) on file. Also, the facility failed to have a written policies and procedures that explained its implementation of state laws and rules relative to ( )

Findings included:

Cross Reference A 0025, the facility failed to provide to Resident #1 who did not have a on file.

A review of the facility's record on revealed that the facility had blank forms in their Administration Facility Book which required staff members to signed off, acknowledging that they have "read it in its entirely and understand its content fully". The "Staff Training" section stated that "All staff will receive ( ) training.

The facility failed to have written policies and procedures that explain its implementation of state laws and rules relative to ( ). The facility also failed to show that residents were given "Health Care Advance Directives" forms at admission.

During an interview on at 8:40 AM, Staff D stated that she saw Resident #1 at 6:00 am on , and she didn't look good. Staff D stated that the resident was out of bed, going to the , and her legs were criss crossed. Staff D asked the resident if she was ok, and the resident said 'Yeah, why?', so staff went back to bed. Staff D did not ask the resident if she needed medical care, and did not conduct further rounds until around 8:00 am, when she found Resident #1 . Staff D reported that she called the Administrator, who told her to call 911. Staff D stated that emergency medical services ( ) told her to begin (, ,), so she put the resident on the floor, and then arrived.

Review of Resident #1's file on revealed that she was diagnosed of , and , . The resident need assistance with self-administration of medications. Resident #1 completed facility forms stating on , "I do not have a , I do not have an Advance Directive. The last progress note was dated . The facility did not have any progress notes regarding Resident #1's passing and failure of the facility to perform . According to the Miami Dade Fire Rescue record, the resident had a prior to the arrival.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968936	08/21/2018
NAME OF PROVIDER OR SUPPLIER **OASIS CENTER CARE CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **4023 SW 138 AVE** **MIAMI, FL 33175**	

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

A review of the ambulance run record on revealed the paramedics arrived at 8:13 am on . They were told that the resident was last seen alive at 11:00 pm the night before. The run record stated Resident #1's body was stiff, , and blue, and that the showed the resident as (no heartbeat).

The facility failed to have written policies and procedures that explain its implementation of state laws and rules relative to ( ). The facility also failed to show that residents were given "Health Care Advance Directives" forms at admission.

Class I

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC

Based on record review and interview, the facility failed to ensure that five out of six sampled staff (Staff A, B, C, D, and E) received the updated training on providing assistance with self-administration of medications and safe medication practices in an assisted living facility.

Findings included:

A review of the facility's personnel on revealed Staff A received 2 hours training providing assistance with self-administered medications and safe medication practices on , 2 hours and 4 hours .
Staff B received 2 hours training providing assistance with self-administered medications and safe medication practices on and 4 hours .

Staff C did not receive training on providing assistance with self-administered medications and safe medication practices. Staff D received 4 hours training providing assistance with self-administered medications and safe medication practices on .

During an interview on at 8:25 AM, Staff C stated "I started working yesterday."

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview the facility failed to file a one day incident report for one out of 11 sampled residents who had in the facility (Resident #1). The facility also failed to file both, a one day and a 15 days incident report for one out of 11 sampled residents who and had multiple

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968936	08/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS CENTER CARE CORP	**4023 SW 138 AVE MIAMI, FL 33175**

SUMMARY STATEMENT OF DEFICIENCIES
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(Resident #2).

Findings included:

1) Review of Resident #1's file on revealed that she was diagnosed of , and , . . Resident #1 completed facility forms stating on , "I do not have a , I do not have an Advance Directive. The facility did not have any progress notes regarding Resident #1's passing and failure of the facility to perform . According to the fire rescue record, the resident had a prior to the arrival.
A review of the ambulance run record on revealed the paramedics arrived at 8:13 am on . They were told that the resident was last seen alive at 11:00 pm the night before. The run record stated Resident #1's body was stiff, , and blue, and that the showed the resident as , (no heartbeat).

2) Review of Resident #2's record on revealed that the progress notes dated stated "Hospitalized-unbalanced, off her bed and , admitted her at a hospital - return same day" "hospitalized - continues unbalance, her md admitted her another hospital."

During an interview on at 9:13 AM, the Administrator stated " I was too busy, I didn't file the adverse incident report."

A review of the hospital records on revealed Resident #2 was admitted at the hospital on and the triage notes stated "patient at the facility with a big gash on the back of her head, LOC (loss of) and patient does not remember the . Assisted Living Facility mate found her on the floor after a slip and and was brought to the ED (emergency department) via ambulance."

A review of Resident #2's hospital records dated revealed "patient baseline presenting to ED via fire rescue from ALF after being found down after assumed GLF (ground level). Patient has laceration to R (right) scalp, as well as revised (staple) laceration to occipital scalp of unknown age. The diagnosis and assessment plan dated stated "Injuries: - Acute left hemispheric hematoma measuring up to 12 mm grade 3 (midline shift from left to right by 5 mm). - along the cerebra convexities and within the basilar cisterns grade 2. - Questionable in the left frontal grade 2. - of the , portion of the right , bone and the right coronal suture grade 2. - Right parietal bone grade 3 with , , extending to orbital roof and greater wing of the sphenoid." The discharge summary dated stated "patient with Hx (history) of , brought from an ALF after have from the bed while sleeping. Person in charge of the ALF reports that patient down 3

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968936	08/21/2018
NAME OF PROVIDER OR SUPPLIER **OASIS CENTER CARE CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **4023 SW 138 AVE** **MIAMI, FL 33175**	

SUMMARY STATEMENT OF DEFICIENCIES
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days prior while attempting to reach the . At that time had an occipital scalp laceration and got repaired at OSH. Patient was found a new left scalp laceration that was repaired by the ED team. CT revealed left holohemispheric Hematoma 12 mm with 5 mm midline shift. Neurosurgery was consulted and patient was started on , anticoagulation held, non- management. Repeat CT showed stable exam therefore no surgical intervention indicated. Right frontal and bone were noted. Plastic was consulted and non- management was deemed appropriate."

Class III

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on observation and record review, the facility failed to have an executed contract by the resident or the resident's legal representative before or at the time of admission for one out of 11 sampled residents (Resident#4).

Finding included:

On at 6:59 AM during the facility tour Resident #4 was observed lying in her bed.

A review of Resident #4's file revealed the resident was admitted to the facility on from a local hospital and the contract signed and dated did not have the monthly fee to be paid by the resident.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968936	**08/21/2018**
NAME OF PROVIDER OR SUPPLIER **OASIS CENTER CARE CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **4023 SW 138 AVE** **MIAMI, FL 33175**	

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0000 - Initial Comments

A Complaint (CCR# 2018012206) Survey was conducted from and concluded on . Oasis Center Care Corp. with limited mental health component (license #12788) had deficiencies at the time of the survey.

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

Based on record review and interview, the facility failed to provide care and services appropriate to meet the needs of two out of 11 sampled residents (Residents #1 and #2). Resident #1 was found unresponsive in the facility, staff failed to perform ( ) and the resident . Resident #2, who required precautions, sustained multiple head from at the facility within two days. The facility also failed to maintain a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, or other changes that resulted in the provision of additional services for two out of 11 sampled residents (Resident #1 and #2).

Findings included:

1) During an interview on at 8:40 AM, Staff D stated that she saw Resident #1 at 6:00 am on , and she didn't look good. Staff D stated that the resident was out of bed, going to the , and her legs were criss crossed. Staff D asked the resident if she was ok, and the resident said 'Yeah, why?', so staff went back to bed. Staff D did not ask the resident if she needed medical care, and did not conduct further rounds until around 8:00 am, when she found Resident #1 . Staff D reported that she called the Administrator, who told her to call 911. Staff D stated that emergency medical services ( ) told her to begin ( ), so she put the resident on the floor, and then arrived.

A review of the ambulance run record on revealed the paramedics arrived at 8:13 am on . They were told that the resident was last seen alive at 11:00 pm the night before. The run record stated Resident #1's body was stiff, , and blue, and that the showed the resident as (no heartbeat).

A review of the facility's record on revealed that the facility's policies and procedures on the caretaker jobs summary stated, "Report changes in the resident's condition/needs immediately to the administrator where further instructions will be given. Maintain/complete records/reports in accordance with the facilities. 11:00 pm -7:00 am shift is required to conduct hourly rounds and bed checks to assure the comfort and safety of all residents. Assist any residents that require help." The facility was

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	AL11968936	08/21/2018
NAME OF PROVIDER OR SUPPLIER **OASIS CENTER CARE CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **4023 SW 138 AVE** **MIAMI, FL 33175**	

SUMMARY STATEMENT OF DEFICIENCIES
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unable to provide documentation or demonstrate that hourly rounds or bed checks were completed by Staff D from 11:00 PM to 7:00 AM on .

During an interview on at 9:13 AM, the Administrator stated on "Resident #1 woke up. She went to the kitchen and then went back to bed. The employee went to call her to eat breakfast, she did not react she was rigid. The employee called me. I instructed her to call 911. The staff were instructed to call me and 911 at the same time, but when it is an emergency they have to call 911 first. It is not that they have to call both at the same time but when there is an emergency they have to call 911 first. She did not call 911 first this time. They shouldn't do it, but they did call the Administrator first. She got scared and called to say that the resident did not react and I told her to call 911 immediately. The staff did not perform and called 911 who told her to start . I did not instruct her to do ." Interview with the staff and the Administrator revealed that they did not know how to perform .

During an interview at 8:40 AM, Staff D stated "I give 30 compressions and mouth breathing. I don't know how many mouth and go back to compression. I do when somebody is not responsive and breathing."

During an interview on at 09:06 AM Staff B stated "I do to a resident who needs it, a resident that is in the necessity of I have to give it. I put the head up, I give 30 compression depending on what 911 says."

During an interview on at 9:13 AM, the Administrator stated "All staff received training. I am trained in . I do if a resident is not breathing, I take the heartbeat, and I do 7-8 compressions."

A review of Resident #1's file on revealed that there were no progress notes regarding the resident's health status and the resident's on . The facility also failed to have updated policy and procedures or documentation that staff received an updated training available for review after Resident #1 was found unresponsive on and staff failed to perform .

In an interview on at 10:28 am trainer confirmed staff received training from the facility. Further interview with the trainer revealed 30 compressions and 2 breaths, this should continue till arrives.

2) A review of Resident #2's health assessment dated revealed the resident did not have any medical history or diagnoses documented. However, the resident was receiving which is used to help relieve nerve pain (, , ,). is used to treat and prevent in the

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	AL11968936	08/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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SUMMARY STATEMENT OF DEFICIENCIES
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stomach and intestines. , is used to treat , used to treat moderate to severe of the 's type. And used to treat , and . The resident needed supervision with ambulation, bathing, dressing, eating, , toileting and transferring. Resident #2 required precautions.

During an interview on at 11:29 AM, the Administrator stated Resident #2 on and went to the hospital but returned to the facility. She revealed Resident #2 was currently in the hospital because she was , and almost on .

A review of the progress notes dated stated "Hospitalized-unbalanced, off her bed and , admitted her at a hospital - return same day" "hospitalized - continues unbalance, her and admitted her another hospital." Record review revealed Resident #2, who had precautions, did not have any intervention in place to prevent the resident from having multiple that resulted in .

A review of the hospital records on revealed Resident #2 was admitted at the hospital on and the triage notes stated "patient at the facility with a big gash on the back of her head, LOC (loss of) and patient does not remember the . Assisted Living Facility mate found her on the floor after a slip and and was brought to the ED (emergency department) via ambulance."

A review of Resident #2's hospital records dated revealed "patient baseline presenting to ED via fire rescue from ALF after being found down after assumed GLF (ground level). Patient has laceration to R (right) scalp, as well as revised (staple) laceration to occipital scalp of unknown age. The diagnosis and assessment plan dated stated "Injuries: - Acute left hemispheric hematoma measuring up to 12 mm grade 3 (midline shift from left to right by 5 mm). - along the cerebra convexities and within the basilar cisterns grade 2. - Questionable in the left frontal grade 2. - of the , portion of the right , bone and the right coronal suture grade 2. - Right parietal bone grade 3 with , extending to orbital roof and greater wing of the sphenoid." The discharge summary dated stated "patient with Hx (history) of , brought from an ALF after have from the bed while sleeping. Person in charge of the ALF reports that patient down 3 days prior while attempting to reach the . At that time had an occipital scalp laceration and got repaired at OSH. Patient was found a new left , scalp laceration that was repaired by the ED team. CT revealed left holohemispheric Hematoma 12 mm with 5 mm midline shift. Neurosurgery was consulted and patient was started on , , anticoagulation held, non- , management. Repeat CT showed stable exam therefore no surgical intervention indicated. Right frontal and , bone were noted. Plastic was consulted and non- , management

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	AL11968936	08/21/2018
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SUMMARY STATEMENT OF DEFICIENCIES
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was deemed appropriate."

Class I

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on interview and record review the assisted living facility failed to record the assistance with self-administration of medications as required for 2 of 6 sampled residents (Residents #4 and #5).

Findings Included:

On , 2018, between 9:50 am - 10:30 am, in interviews with Residents #4 and #5 revealed they received their morning medications.

On , 2018 between 9:50 am - 10:30 am a review of the facility's medication observation records (MORs) revealed that the facility failed to sign the record at the time the medications were given or offered to the residents.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation, record review, and interview, the facility failed to discard medications that were abandoned within 30 days for four out of 11 sampled residents (#8, #9, #10, and #11) .

Findings included:

During the facility tour on at 6:59 AM three medications bags were found in a locked closet. Two of the three bags had and 0.5 mg and in a locked black box inside of the refrigerator was 25 mg .

During an interview on at 7:10 AM, Staff B pointed at the bags and stated "not here, not here."

A review of the facility admission and discharge book revealed Resident #8 was discharged on , Resident #9 was discharged on , Resident #10 was discharged on , and Resident # 11 was discharged on .

Class III

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SUMMARY STATEMENT OF DEFICIENCIES
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0076 - ( ) - 58A-5.0186 FAC

Based on record review and interview, the facility failed to perform , , for one out of 11 sampled resident (Resident #1) who did not have a ( ) on file. Also, the facility failed to have a written policies and procedures that explained its implementation of state laws and rules relative to ( )

Findings included:

Cross Reference A 0025, the facility failed to provide to Resident #1 who did not have a on file.

A review of the facility's record on revealed that the facility had blank forms in their Administration Facility Book which required staff members to signed off, acknowledging that they have "read it in its entirely and understand its content fully". The "Staff Training" section stated that "All staff will receive ( ) training.

The facility failed to have written policies and procedures that explain its implementation of state laws and rules relative to ( ). The facility also failed to show that residents were given "Health Care Advance Directives" forms at admission.

During an interview on at 8:40 AM, Staff D stated that she saw Resident #1 at 6:00 am on , and she didn't look good. Staff D stated that the resident was out of bed, going to the , and her legs were criss crossed. Staff D asked the resident if she was ok, and the resident said 'Yeah, why?', so staff went back to bed. Staff D did not ask the resident if she needed medical care, and did not conduct further rounds until around 8:00 am, when she found Resident #1 . Staff D reported that she called the Administrator, who told her to call 911. Staff D stated that emergency medical services ( ) told her to begin (, ,), so she put the resident on the floor, and then arrived.

Review of Resident #1's file on revealed that she was diagnosed of , and , . The resident need assistance with self-administration of medications. Resident #1 completed facility forms stating on , "I do not have a , I do not have an Advance Directive. The last progress note was dated . The facility did not have any progress notes regarding Resident #1's passing and failure of the facility to perform . According to the Miami Dade Fire Rescue record, the resident had a prior to the arrival.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968936	08/21/2018
NAME OF PROVIDER OR SUPPLIER **OASIS CENTER CARE CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **4023 SW 138 AVE** **MIAMI, FL 33175**	

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

A review of the ambulance run record on revealed the paramedics arrived at 8:13 am on . They were told that the resident was last seen alive at 11:00 pm the night before. The run record stated Resident #1's body was stiff, , and blue, and that the showed the resident as (no heartbeat).

The facility failed to have written policies and procedures that explain its implementation of state laws and rules relative to ( ). The facility also failed to show that residents were given "Health Care Advance Directives" forms at admission.

Class I

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC

Based on record review and interview, the facility failed to ensure that five out of six sampled staff (Staff A, B, C, D, and E) received the updated training on providing assistance with self-administration of medications and safe medication practices in an assisted living facility.

Findings included:

A review of the facility's personnel on revealed Staff A received 2 hours training providing assistance with self-administered medications and safe medication practices on , 2 hours and 4 hours .
Staff B received 2 hours training providing assistance with self-administered medications and safe medication practices on and 4 hours .

Staff C did not receive training on providing assistance with self-administered medications and safe medication practices. Staff D received 4 hours training providing assistance with self-administered medications and safe medication practices on .

During an interview on at 8:25 AM, Staff C stated "I started working yesterday."

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview the facility failed to file a one day incident report for one out of 11 sampled residents who had in the facility (Resident #1). The facility also failed to file both, a one day and a 15 days incident report for one out of 11 sampled residents who and had multiple

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

(Resident #2).

Findings included:

1) Review of Resident #1's file on revealed that she was diagnosed of , and , . . Resident #1 completed facility forms stating on , "I do not have a , I do not have an Advance Directive. The facility did not have any progress notes regarding Resident #1's passing and failure of the facility to perform . According to the fire rescue record, the resident had a prior to the arrival.
A review of the ambulance run record on revealed the paramedics arrived at 8:13 am on . They were told that the resident was last seen alive at 11:00 pm the night before. The run record stated Resident #1's body was stiff, , and blue, and that the showed the resident as , (no heartbeat).

2) Review of Resident #2's record on revealed that the progress notes dated stated "Hospitalized-unbalanced, off her bed and , admitted her at a hospital - return same day" "hospitalized - continues unbalance, her md admitted her another hospital."

During an interview on at 9:13 AM, the Administrator stated " I was too busy, I didn't file the adverse incident report."

A review of the hospital records on revealed Resident #2 was admitted at the hospital on and the triage notes stated "patient at the facility with a big gash on the back of her head, LOC (loss of) and patient does not remember the . Assisted Living Facility mate found her on the floor after a slip and and was brought to the ED (emergency department) via ambulance."

A review of Resident #2's hospital records dated revealed "patient baseline presenting to ED via fire rescue from ALF after being found down after assumed GLF (ground level). Patient has laceration to R (right) scalp, as well as revised (staple) laceration to occipital scalp of unknown age. The diagnosis and assessment plan dated stated "Injuries: - Acute left hemispheric hematoma measuring up to 12 mm grade 3 (midline shift from left to right by 5 mm). - along the cerebra convexities and within the basilar cisterns grade 2. - Questionable in the left frontal grade 2. - of the , portion of the right , bone and the right coronal suture grade 2. - Right parietal bone grade 3 with , , extending to orbital roof and greater wing of the sphenoid." The discharge summary dated stated "patient with Hx (history) of , brought from an ALF after have from the bed while sleeping. Person in charge of the ALF reports that patient down 3

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SUMMARY STATEMENT OF DEFICIENCIES
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days prior while attempting to reach the . At that time had an occipital scalp laceration and got repaired at OSH. Patient was found a new left scalp laceration that was repaired by the ED team. CT revealed left holohemispheric Hematoma 12 mm with 5 mm midline shift. Neurosurgery was consulted and patient was started on , anticoagulation held, non- management. Repeat CT showed stable exam therefore no surgical intervention indicated. Right frontal and bone were noted. Plastic was consulted and non- management was deemed appropriate."

Class III

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on observation and record review, the facility failed to have an executed contract by the resident or the resident's legal representative before or at the time of admission for one out of 11 sampled residents (Resident#4).

Finding included:

On at 6:59 AM during the facility tour Resident #4 was observed lying in her bed.

A review of Resident #4's file revealed the resident was admitted to the facility on from a local hospital and the contract signed and dated did not have the monthly fee to be paid by the resident.

Class III