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
	AL11963986	A. BUILDING: _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAM HOME INC	158 WEST 8TH STREET HIALEAH, FL 33010

(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 Second Follow-up Survey to a Complaint Investigation Survey (CCR #2012009423) was conducted at Adam Home Inc. on [redacted] At the time of th survey, deficiencies were identified.	{A 000}		
{A 025} SS=D	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor 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 individual. (c) General awareness of the resident ' s whereabouts. The resident may travel 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; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.	{A 025}		

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
	AL11963986	A. BUILDING: _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAM HOME INC	158 WEST 8TH STREET HIALEAH, FL 33010

(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 025}	Continued From page 1	{A 025}		

This Statute or Rule is not met as evidenced by:
Based on observation, resident record review, and interviews the assisted living facility failed to provide the appropriate care and services for 1 out of 3 (resident #3) applicable sampled residents. The assisted living facility failed to have a written record, updated as needed, of any significant changes for 2 out of 5 (resident #4, #5) sampled residents.

Findings Include:

1) In an interview with the administrator on _ _ _ _ at approximately 9:38 AM, she stated resident #4 was here for two weeks, maybe more. She stated he did not pay to live here. She stated the police took him to Jackson Hospital. She stated they took him because he was acting aggressive. She stated that she did not allow him back here. She stated that he did not pay so he could not come back here. She stated she spoke to the police and told them that he could not come back here. She stated that he called the police. She stated that he called the police because she asked him for money. She stated he told the police he does not want to pay to live here.

2) Record review of resident #4's file revealed he was admitted to the facility on _ _ _. Resident progress notes revealed resident #4 left the facility on _ and stated he was leaving to another place and returned on _ _ _ from the hospital. Documentation on _ revealed resident #4 wanted to stay at the facility and called the social security office to change his address. Record review revealed the facility did not document the situation which occurred with the police on _ _ _. Record review revealed a

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
	AL11963986	A. BUILDING: _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAM HOME INC	158 WEST 8TH STREET HIALEAH, FL 33010

(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 025}	Continued From page 2	{A 025}		

police report was generated as an information report on .

3) In an interview with the administrator on . at approximately 10:12 AM, she stated resident #5 went to the hospital because he had bad stomach pains and he did not come back because he did not want to come back. She stated every . three people and he wanted to live by himself.

4) Record review of resident #5's file revealed he was admitted to the facility on . Record review revealed a contract dated . which was not signed by or on behave of resident #5. Resident progress notes revealed on . he was admitted from the hospital, on . showed he went to Citrus program and his nurse takes care of him at citrus, but there was no documentation of him going to the hospital due to stomach pains and not coming back to the facility.

5) Observations on . at approximately 10:31 AM found a small refrigerator in the kitchen of the facility. Observations found the following medications in the small refrigerator which were prescribed to resident #3:
- . 100 U 10 ml via. Inject 10 units the morning and in the evening. Dated .
- . 100 U 10 ml via. Inject 15 units in two times a day. Dated .

6) In an interview with the administrator and staff #1 on . at approximately 10:44 AM, she stated that the nurse comes in for both {resident #2 and resident #3}. After requesting the records, she stated that the nurse only comes in and gives . to only resident #2. Staff #1 stated that she is giving resident #3 her . She stated that no one else does it but her. She stated resident

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
	AL11963986	A. BUILDING: _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAM HOME INC	158 WEST 8TH STREET HIALEAH, FL 33010

(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 025}	Continued From page 3	{A 025}		

#3 does not have Medicaid so she does not have a nurse. She stated she put in an application for Medicaid.
7) Record review of resident #3's Medication Observation Records (MORs) revealed that staff #1 and staff #2 initialed for giving the ... to resident #3. Record review of a log made by staff #1 showed the dates and times which she administered the ... for resident #3.
8) In an interview with staff #1 on ... at approximately 10:51 AM, she stated that she is the only one that gives the insulin.
Record Review of staff #1's personnel file, whose a application was dated 10-1 ... an assistance with medication training dated 9-2... .
In an interview with staff #1 on 02-2... approximately 11:01 AM, she stated in June ... July ... will have everything. She stated she is a nursing student. She stated she is not a nurse now. She stated she puts the insulin ... the syringe. She stated she injects the insulin ... resident #3's arm. She stated she does it for her. She stated that staff #2 is not a nurse in America but she is a nurse in her country.
11) In an interview with resident #3 on 02-2... ... approximately 11:07 AM, she stated staff #1 gives her her insulin. ... stated another lady gives it to her but she does not know when. She stated that she gets insulin ... in the evening times before dinner. She stated she has been on insulin ... 5 years.
12) In an interview with the administrator on 02-2... approximately 11:56 AM, she acknowledged that she did not document each incident for resident #4 or resident #5.
13) In an interview with the administrator on 02-2... ... approximately 12:09 PM, she acknowledged the findings and stated that resident #3 needs the medication. She stated she

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
	AL11963986	A. BUILDING: _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAM HOME INC	158 WEST 8TH STREET HIALEAH, FL 33010

(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 025}	Continued From page 4 does not have a nurse for her. She asked if resident #3 should be discharged. She stated that she does not have a nurse that works at the facility. 14) In a voicemail left by the Hialeah Police Officer {which responded to the facility on on at approximately 3:21 PM, he stated the facility decided resident #3 was being argumentative and belligerent and they decided to keep things peaceful and release him. Class III UNCORRECTED	{A 025}		
A 053 SS:	58A-5.0185(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities which provide medication administration a staff member, who is licensed to administer medications, must be available to administer medications in accordance with a health care provider ' s order or prescription label. (b) Unusual reactions or a significant change in the resident ' s health or behavior shall be documented in the resident ' s record and reported immediately to the resident ' s health care provider. The contact with the health care provider shall also be documented in the resident ' s record. (c) Medication administration includes the conducting of any examination or testing such as glucose testing or other procedure necessary for the proper administration of medication that the resident cannot conduct himself and that can be performed by licensed staff. (d) A facility which performs clinical laboratory tests for residents, including glucose testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of	A 053		

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
	AL11963986	A. BUILDING: _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAM HOME INC	158 WEST 8TH STREET HIALEAH, FL 33010

(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 053	Continued From page 5	A 053		

1988 (CLIA) and Part I of Chapter 483, F.S. A valid copy of the State Clinical Laboratory License and the CLIA Certificate must be maintained in the facility. A state license or CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a State Clinical Laboratory License or a CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents ' own equipment. Information about the State Clinical Laboratory License and CLIA Certificate is available from the Clinical Laboratory Licensure Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)487-3109.

This Statute or Rule is not met as evidenced by:
Based on observation, record review, and interview the assisted living facility failed to ensure licensed staff administered medications to 1 out of 3 (resident #3) applicable sampled residents.

Findings Include:

1) Observations on [redacted] at approximately 10:31 AM found a small refrigerator in the kitchen of the facility. Observations found the following medications in the small refrigerator which were prescribed to resident #3:
- [redacted] 100 U 10 ml via. Inject 10 units the morning and in the evening. Dated [redacted]
- [redacted] 100 U 10 ml via. Inject 15 units in two times a day. Dated [redacted]
2) In an interview with the administrator on [redacted] at approximately 10:39 AM, she stated resident #2 and resident #3 are the only residents

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
	AL11963986	A. BUILDING: _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAM HOME INC	158 WEST 8TH STREET HIALEAH, FL 33010

(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 053	Continued From page 6	A 053		

receiving
3) Record review of resident #3's physician orders for 15 u2D was dated

4) In an interview with the administrator and staff #1 on at approximately 10:44 AM, she stated that the nurse comes in for both {resident #2 and resident #3}. After requesting the records, she stated that the nurse only comes in and gives to only resident #2. Staff #1 stated that she is giving resident #3 her She stated that no one else does it but her. She stated resident #3 does not have Medicaid so she does not have a nurse. She stated she put in an application for Medicaid.
5) Record review of resident #3's Medication Observation Records (MORs) revealed that staff #1 and staff #2 initialed for giving the to resident #3. Record review of a log made by staff #1 showed the dates and times which she administered the for resident #3.
6) In an interview with staff #1 on at approximately 10:51 AM, she stated that she is the only one that gives the She stated that staff #2 works three days on the weekends. She stated she works Saturday, Sunday, and she leaves Monday.
7) Record Review of staff #1's personnel file, whose a application was dated found an assistance with medication training dated

8) In an interview with staff #1 on at approximately 11:01 AM, she stated in or she will have everything. She stated she is a nursing student. She stated she is not a nurse now. She stated she puts the into the syringe. She stated she injects the into resident #3's arm. She stated she does it for her. She stated that staff #2 is not a nurse in America but she is a nurse in her country.

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
	AL11963986	A. BUILDING: _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAM HOME INC	158 WEST 8TH STREET HIALEAH, FL 33010

(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 053	Continued From page 7 9) In an interview with resident #3 on _ _ _ _ at approximately 11:07 AM, she stated staff #1 gives her her _ _ _ _. She stated another lady gives it to her but she does not know when. She stated that she gets _ _ _ just in the evening times before dinner. She stated she has been on _ _ _ for 5 years. 10) In an interview with the administrator on _ _ _ _ at approximately 12:09 PM, acknowledged the findings and stated that resident #3 needs the medication. She stated she does not have a nurse for her. She asked if resident #3 should be discharged. She stated that she does not have a nurse that works at the facility. Class II	A 053		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Adam Home Inc
158 West 8th Street
Hialeah, FL 33010

CCR#2012009423 2nd F/u

Dear Administrator:

This letter reports the findings of a 2nd revisit survey to a complaint conducted on , 2013by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies and Plan of Correction (State Form 3020), which references the uncorrected deficiencies and/or new deficiencies, identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than 2013.**

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call this office at (305) 593-3100.

Sincerely,

for Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure

BBT7

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone (305) 593-3100; Fax (305) 593-3121