STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965295	
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
lii	8395 Sw 112 Street Miami, FL 33156	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0008 - 429.26(4-6) Fs; 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0010 - 429.26(1&9) Fs; 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= G
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0053 - 58a-5.0185(4) Fac - Medication - Administration S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0077 - 429.176 Fs; 58a-5.019(1) Fac - Staffing Standards - Administrators S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D
St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D
St - A - Z827 - 408.812, Fs - Unlicensed Activity S-S= C

Specific Tag Findings:

0000-Initial Comments

A Monitoring survey was conducted on and concluded on TLC III had deficiencies found at the time of the survey.

0008-Admissions - Health Assessment 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview the facility failed to completed health assessments for 3 out of 7 (#1, #2, and #4) sampled residents.

The findings included:

Resident #1's record did not have a health assessment. Resident #2's health assessment (Form 1823) did not indicate if the resident met residency criteria to live in an assisted living facility. Resident # 4's health assessment was not signed by a healthcare provider.

Interview on at 10:00 AM with Staff C revealed that she did not know the residents were missing that on in the files.

Class III

0010-Admissions - Continued Residency 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, interview, and record review the facility failed to follow admission licensure standards and determine the appropriateness for continued residency for two out of 7 sampled residents (Residents #1 and #5). This was evidenced by the facility 's failure to properly assess and

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failure to provide the required nursing care and services for 1 of 7 sampled residents (Resident #1) with a who required total care due to her declining medical condition. The facility failed to ensure that 2 out of seven sampled residents (Residents #3 and #5) had a completed health assessment every three years.

The findings included:

Observed Resident #1 on at 5:10 AM, she was sitting at the dining eating her breakfast.

In an interview with the 11 pm- 7 am caregiver on at 5:45 AM, she stated that Resident #1 was a "day care" resident but slept at the facility. The caregiver stated that Resident #1 spoke infrequently and the staff attempted to meet her needs as best possible. The caregiver stated that the resident required assistance with all activities of daily living (ADL) and the resident fed herself. She stated that she showered the resident daily and provided her the breakfast meal. The caregiver stated that the resident had recently been removed from hospice services but she was not sure of the reason. She stated Resident #1 had a and the collection bag was changed by the facility manager when necessary.

Review of the facility 's current admission and discharge log indicated six residents currently admitted to the facility as per licensure. Further review of the log indicated that Resident #1 had been admitted to the facility on and discharged on to day care services. Review of the facility's day care contract dat /12 indicated Resident #1 client was to receive day care services from 7 am to 7 pm with additio rs incurring an extra charge and would receive 3 meals, breakfast, lunch and dinner. Review of the 2015 Medication Observation Record (MOR) for Resident #1 indicated the facility staff were documenting prescribed medications being administered to the resident daily at 8 AM and 8 PM from / until

In an interview with Resident #6 on at 6:30 AM, she stated that she lived in the facility since 2013. Resident #6 was alert and oriented and stated that Resident #1 is " always " at the facility, and she eats all her meals with the current residents. Resident #6 stated that Resident #1 sleeps in # , which is adjacent to Resident #6's

Observation of Resident #1 on at 7:00 AM, the unlicensed caregiver wheeled Resident #1 in a wheelchair to # . The caregiver lifted and transferred the resident onto a bed. The care giver loosened Resident #1 's pants revealing a collection bag. The care giver stated that she did not care for the site or the collection bag.

In an interview with the day shift facility manager on at 8:00 AM she stated that Resident #1

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had been a previous resident but now she was a " day care resident." The manager stated that the resident received meals, ADL care, medication administration and regularly slept at the facility. She stated that Resident #1 had been on hospice care for and recently was discharged from the services at the end of 2015. She stated that Resident #1 had a and that the hospice nurse had made visits to care for the . The manager stated that since the resident 's discharge from hospice services, she now cares for the changes the collection bag as needed. She provided for surveyor observation, prescribed supplies including collection bags and adhesive patches, she was utilizing for the resident 's care. The manager stated she was not a licensed nurse.

Review of Resident #1 's hospice medical record dated on indicated the resider advanced 's with . The resident has history of for 6 years in 2014 required surgical intervention recurrent ie reside was diagnosed with r complications from had a hist f . The record indicated the resident was alert but with poor verbal communication, in Chinese language, intelligible words and incoherent at times. The resident required total assistance with all ADL care and was non-ambulato nented as an risk due to the , requiring a pureed diet and at risk for due to the ice, immobility a poor appetite. Further review of the hospice care plan indicated routine nursing assessment and monitoring for and function. The facility staff was instructed to notify the hospice of any concerns.

In an observation of staff assistance with self administration of medication for Resident #1 on at 9:45 AM the unlicensed facility manager prepared the prescribed medications for the The care giver dispensed several tablets from the prepackaged pharmacy containers into a bowl and crushed the medications into a fine powder. She then mixed the powdered medications with other prescribed liquid medications and apple sauce. The care giver proceeded to scoop the mixture into a spoon and feed it to Resident #1.

Review of Resident #1 Medication Observation Record (MOR) indica was to receive Caltrate 600 plus D twice dav DR 20 mg daily, 650 mg twice daily, Cerovite liq nl daily and elixir 7.5 ml daily. Review of the pharmacy prepackaged 650 mg indicated a printed blue label stating the "tablet to be swallowed wh w or crush." Further review of the 2015 MOR indicated the resident had been administered the tablet every day at 8 am and 8 pm which was documented by various care givers i

In an interview with the unlicensed facility manager on at 10:00 AM, she stated that Resident #1 could not swallow pills and required all her medications to be crushed or be in liquid form. The

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manager stated that she was unaware that the should not be crushed. The manager stated that she was not a licensed nurse and that she could only assist the resident with self administration of medications. She stated the resident was not able to take her own medications and required the facility staff to administer the medications to her.

In a further interview with the facility manager on at 12:00 PM she stated that Resident #1 was receiving home health services for physical only, starting . She stated that the resident was not being visited by a home health nurse to assess the site or change the collection bag. The manager stated that she had not documented any observations or care provided for the site.

In an interview with the facility's assistant administrator on at 1:00 PM she stated that Resident #1 was a day care resident and had not been admitted to the facility. She indicated that the facility staff provided all daily ADL care and provided medication management to the resident. The assistant manager stated that Resident #1 was unable to care for the herself and indicated that the unlicensed facility day manager was providing care services to Resident #1 for the She stated that there was no resident health assessment completed for Resident #1 and no physician orders for the care since the resident had been discharged from hospice services. She stated that she ble to provide any documentation of care provided by the facility staff. The assistant administrator stated that she was unaware that if the resident was unable to perform self - care, then a licensed nurse must provide assistance for care and services of the unlicensed staff is not to be delegated the nursing service. She was unaware that the resident had a history of complications with the function. The assistant administrator stated that she was aware of the facility licensure census limitations and the facility was providing daily care and services to Resident #1.

In an interview with Resident #1's family member on she stated that she had an agreement with the facility to provide day care services for Resident #1 between 7 AM and 7 PM, but the resident would often spend the night at the facility when necessary.

Resident #3's last health assessment documented that the resident needed assistant with self-administration of medication and the the resident also needed me administration. Moreover, the last health assessment in Resident #3's file was dated .

Review of Resident #5's health assessment form dated on indicated medical diagnosis of . The assessment indicated that the resident required assistance with all of her ADL care and assistance with self administration of medications. The resident was documented as requiring a pureed diet.

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In an observation of Resident #5 on at 10:00 AM, the resident was sitting at the dining being fed by a caregiver. The resident was observed to be alert to name only and nonverbal. The ly manager was observed to place Resident #5's prescribed medications including , Levothyroxin,Vitamin D 3, Lactolose solution, , and 600+ D1, into a cup and then spoon fed the medications to resident. The resident was unable to assist with self administering her medications and the caregiver did not inform the resident of the medications she was providing to the resident.

In an interview with the manager on at 10:05 AM she stated that Resident #5 was unable to feed herself and required total staff assistance for all meals. She stated that the resident was unable to assist to take her own medications and the health assessment was not an accurate reflection of the resident's present condition.

Class II

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

Based on observation, record review, and interview the facility failed to honor resident rights. The facility failed to ensure that 2 out of 7 sampled residents (Residents #2 and #3) were not blocked by sofa chairs and recliners while in lying bed. The facility failed to ensure that 2 out of 7 sampled residents (#5 and #6) were treated with consideration and recognition of personal dignity.

The findings included:

Observation during facility tour on at 5:45 AM showed Resident (#2) sleeping in (# 1) with a sofa blocking Resident 's (#2) bed. Also, Resident (# 3) sleeping in (#2) with a sofa/ wheelchair blocking Resident 's (#3) bed.

Interview on at 10:34 AM with Staff B and D revealed that Resident #2 went to the hospital for the incident c when Resident #2 broke her hip.

Further observation during tour on at 5:32 AM showed Resident (#6) having a shower assisted by Staff B.

In an interview with Resident #6 on at 6:30 AM she indicated that the facility caregiver awakened her every day at 5 AM to take a shower. She stated that she " preferred to sleep in a little later" since she was not a "morning " person and she did not understand why she had to awaken so early. She stated that she had expressed her wishes to the staff but they had informed her that she needed to be showered before the other residents awakened. She stated that she was not happy with the current schedule because it caused her to asleep after eating breakfast.

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In an interview with the 11 pm -7 am caregiver on at 7:00 AM, she stated that she was instructed to provide morning activity of daily living (ADL) care to at least 2 of the 7 current residents before she goes off duty at 7 AM. She stated that she provided Resident #6 with assistance with showering. She stated that resident #6 is alert and oriented and can make her wishes known.

Review of Resident #5's health assessment form dated on indicated medical diagnosis of . The assessment indicated that the resident required assistance with all of her activities of g (ADL) such as eating. The resident was documented as requiring a pureed diet.

In an observation on at 8:35 AM Resident #5 was transferred to a recliner chair by the facility staff after receiving her morning ADL care. Resident #5 was observed to remain in the chair and was not provided breakfast until surveyor intervention at 9:25 AM.

In an interview with the caregiver on at 9:25 AM she stated that Resident #5 was unable to feed herself and required staff assistance to eat her meals. At 9:30 AM, the resident was observed being fed breakfast by the care giver.

Class III

0053-Medication - Administration 58A-5.0185(4) FAC

Based on observation, interview, and record review the facility failed to ensure that unlicensed staff only provided assistance with self -administration of medications. The facility failed to have a licensed personnel administer medications to 2 out of 7 (Residents #1 and #5).

The findings included:

Review of Resident #1 's medical record dated on indicated the resident h ced with . The resident was diagnosed with . The resid . language, intelligible words and incoherent at times. The resident required total assista all activities of daily living (ADL) care and was non-ambulatory. She is documented as an risk due to the , requiring a pureed diet.

In an observation of staff assistance with self administration of medications for Resident #1 on at 9:45 AM the unlicensed facility manager prepared the prescribed medications for the . The caregiver dispensed several tablets from the prepackaged pharmacy containers into a bowl and crushed the medications into a fine powder. She then mixed the powdered medications with other prescribed liquid medications and apple sauce. The caregiver proceeded to scoop the mixture into a spoon and feed it to Resident #1.

Review of Resident #1's Medication Observation Record (MOR) indicated the resident was to receive

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Caltrate 600 plus D twice dav. DR 20 mg daily, 650 mg twice daily, Cerovite liqu nl daily and elixir 7.5 ml daily. Review of the pharmacy prepackaged 650 mg tablets indicated a printed blue label stating the "tablet to be swallowed wh ... not chew or crush." Further review of the 2015 MOR indicated the resident had been administered the tablet every day at 8 am and 8 pm which was documented by various caregivers initials.

In an interview with the unlicensed facility manager on at 10:00 AM, she stated that Resident #1 could not swallow pills and required all her medications to be crushed or be in liquid form. The manager stated that she was unaware that the should not be crushed. The manager stated that she was not a licensed nurse, and that she could only assist the resident with self administration of medications. She stated the resident was not able to take her own medications and required the facility staff to administer the medications to her.

Review of Resident #5's health assessment form dated on indicated medical diagnosis of ... The assessment indicated that the resident required assistance with all of her ADL care and assistance with self administration of medications. The resident was documented as requiring a pureed diet.

In an observation of Resident #5 on at 10:00 AM, the resident was sitting at the dining being fed by a caregiver. The resident was observed to be alert to name only and bal. The ty manager was observed to place Resident #5's prescribed medications including , Levothyroxin,Vitamin D 3, Lactolose solution, , and 600+ D1, into a cup and then spoon fed the medications to resident. The resident was unable to assist with self administering her medications and the caregiver did not inform the resident of the medications she was providing to the resident.

In an interview with the manager on at 10:05 AM she stated that Resident #5 was unable to feed herself and required total staff assistance for all meals. She stated that the resident was unable to assist to take her own medications and the health assessment was not an accurate reflection of the resident's present condition.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC

Based on observation, interview and record review the facility failed to properly store and administer medications as evidenced by the failure to store resident medications and failure to dispense medications as ordered by the physician and pharmacy recommendation for 3 of 7 sampled residents (Residents #1, #4, and #6).

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The findings included:

In an observation of assistance with self administration of medication for Resident #1 on at 9:45 AM the unlicensed facility manager prepared the prescribed medications for the resident. The caregiver dispensed several tablets from the prepackaged pharmacy containers into a bowl and crushed the medications into a fine powder. She then mixed the powdered medications with other prescribed liquid medications and apple sauce. The care giver proceeded to scoop the mixture into a spoon and feed it to Resident #1.

Review of Resident #1 Medication Observation Record (MOR) indica[illegible] was to receive Caltrate 600 plus D twice day. DR 20 mg daily, 650 mg twice daily, Cerovite liqu nl daily and elixir 7.5 ml daily. Review of the pharmacy prepackaged 650 mg tablets indicated a printed blue label stating the "tablet to be swallowed wh[illegible] not chew or crush". Further review of the 2015 MOR indicated the resident had been administered the tablet every day at 8 am and 8 pm which was documented by various caregivers initials.

In an interview with the unlicensed facility manager on at 10:00 AM, she stated that resident #1 could not swallow pills and required all her medications to be crushed or be in liquid form. The caregiver stated that she was unaware that the should not be crushed. She stated that she would inform the Administrator and would notify the resident's physician.

Observation on at 5:30 AM revealed that there were medications (unlabeled) inside Residents #4 and #6's [illegible]ident # 4, # , had , Medicade Pads, Medication pads, and (all unlabeled). Resident #6, # , had 0.05 % (unlabeled), and Simply (nasal mist) 10 % (unlabeled).

An interview on at 6:10 AM with Staff A revealed that she did not know that those medications need to be label

Class III

0077-Staffing Standards - Administrators 429.176 FS; 58A-5.019(1) FAC

Based on record review and interview the facility failed to have proof of the Administrator's high school diploma or GED.

Findings included:

A record review on at 10:00 AM showed that the facility's Administrator did not have evidence

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of having a high school diploma or its equivalent. The Administrator completed CORE training on .

Interview with Staff A on at 11:50 AM she acknowledged that the Administrator did not have a high school diploma in her personnel file at time of the survey.

Class III

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

Based on observations interview the facility failed to have 3-day supply of non-perishable food and failed to add substitutions to the menu.

The findings included:

During tour of the facility conducted on at 5:30 AM showed that there was no emergency food which included protein, fruits, vegetables, milk and starches in the facility at time of the survey for a census of seven residents.

An interview on with Staff D confirmed the facility did not have emergency food.

Class III

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

Based on record review and interview the facility failed to have a signed consent for unlicensed staff to assist with self administration of medications for 1 out of 7 sampled residents (Resident #4).

The findings included:

Record review on at 10:00 AM showed that Resident 4 had a Medication Observation Record for the daily self ac tion of medications by unlicensed staff. Resident # 4's record review showed there was not a consent for unlicensed staff to assist with self-administration of medications.

Interview on at 10:00 AM with Staff C revealed that she did not know the residents were missing that on in the files.

Class III

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

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Based on record review and interview the facility failed to report an incident after the occurrence of an adverse incident for 1 out of 7 sampled residents (Resident #2).

The findings included:

Observation on at 5:45 AM revealed that Resident #2 was sleeping # with a sofa blocking the bed.

Record review on at 10:00 AM showed documentation (Incident/Accident Report) dated on , which sta was changing another Patient, and I heard another Patient screaming; when I went I see her on the floor, she was in , I called the Supervisor, ar et her known what has happened." Moreover, facility did not report an adverse incident report ( ) within 1 day and the 15 days full report to the agency for Resident #2.

Record review on at 10:15 AM showed a written documentation (dated) with the following informati dent #2 is doing fine. She bumped the side of her head. Nurse from of the insurance company (name was written) came to dress her arm 3x week and everything is healed and okay. However, there was no documentation that the facility reported this incident to the agency with 1 day. Further record review on at 10:25 am showed that there written ntation regarding steps taken to prevent recurrence with Resident #2 falling on and .

An interview on at 6:30 AM Resident #6 stated, "Resident #2 two times and broke her hip."

on at 10:34 AM with Staff B and D revealed that Resident #2 went to the hospital for ent c when Resident #2 broke her hip.

Class III

Z827-Unlicensed Activity 408.812, FS

Based on observation, record review, and interview the facility failed to obtain a licensure capacity increase prior to providing personal care, meals, and administration of medications to 1 out of 7 residents (Resident #1). The facility provided services to residents outside the current license capacity of six.

Findings included:

Observation on at 5:10 AM showed that Resident #1 was seating at the dining breakfast.

Further observation on at 5:40 AM showed the following information: Ointment

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spray, Vnc 20 % ointment with facility address on (8395 SW 112 St Miami 33156) with indication to apply twice daily. Moreover, there was an Lac Care 12 % with indications to be applied to legs and feet after bath daily. Moreover, these medications were inside # 's .

In an interview with Resident #6 on at 6:30 AM, she stated that she lived in the facility since 2013. Resident #6 was alert and oriented and stated that Resident #1 is " always " at the facility, and she eats all her meals with the current residents. Resident #6 stated that Resident #1 sleeps in # , which is adjacent to Resident #6's .

Record review on at 9:16 AM revealed that Resident #1's had a medication observation record in the facility and Resident #1 received her daily medication at the facility.

Further record review on at 9:30 AM revealed that Resident #1 had a written doc signed on from Staff C and D (7-3 shift) indicating the following information: The came for R #1.

Interview on Staff B and D stated that Resident #1 had in the facility. Also, Staff B and D stated that Resident #1 stayed in the facility most of the time. However, she was a daycare.

In an interview with Resident #1's family member on she stated that she had an agreement with the facility to provide day care services for Resident #1 between 7 AM and 7 PM, but the resident would often spend the night at the facility when necessary.

Unclassified deficiency

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Iii
8395 Sw 112 Street
Miami, FL 33156

Dear Administrator:

This letter reports the findings of a Monitoring survey that was conducted on , 2015 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe.

Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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(s). Should you have any questions please call Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Date: 3/4/15
3:45pm

Barbara Clayton

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure
XG90

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

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Iii
8395 Sw 112 Street
Miami, FL 33156

Attention: Barbara Clifford, Administrator

Dear . Clifford:

This letter reports finding of a Monitoring survey conducted from - by representatives of the Agency for Health Care Administration. You are directed to comply with the tangible steps outlined below in order to correct the deficient practices. Attached are the deficiencies noted in the investigation.

The investigation resulted in findings of noncompliance with the following area:

A 010 – Admission – Continued Residency – Class II – Your Assisted Living Facility failed to properly assess a resident for criteria for continued residency and failed to provide nursing services to a resident requiring total care and nursing services.

Z 827 – Unlicensed Activity – Unclassified – Your Assisted Living Facility exceeded your licensed capacity of 6 residents and had 7 residents at the time of survey.

Your facility must comply with the following:

1) Your facility must create and implement a formal policy regarding assessment for admission criteria to include how your facility's assessment and ability to meet the resident needs will be included in the resident record. No residents whose care and needs outside the scope of an assisted living facility standard license may be admitte This must include, at a minimum, the following components:

- How residents will be assessed prior to admission for appropriateness for residency.
- Procedures for documenting changes in condition, contact with medical and service providers and communication between staff regarding resident status.

This shall be completed by .

2) All residents currently residing in the facility are required to have new updated health assessments indicating their appropriateness for continued residency i ly. Be advised that the standard license allows admi resident with a as long as the resident can perform his/her own care. If the resident is unable to perform the care, a nurse must be on staff or be contracted with to provide assistance to

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

Tlc Iii

, 2015

perform the function. The nurse cannot delegate the function to unlicensed personnel. The facility must have a complete record of each resident of the facility, including an updated complete health assessment for each resident (AHCA form 1823) completed by a medical provider. The resident record must also contain documentation of all significant changes in the resident's status and correspondence with all medical and service providers and responsible parties. Any care services provided by the facility should be documented in the resident's medical record.
This shall be completed by

3) All staff providing assistance with self-administration to residents must be re-trained in correctly providing assistance with self-administration of medication. The training shall be conducted by a registered nurse or licensed pharmacist using the curriculum provided by the Department of Elder Affairs at their website:

http://elderaffairs.state.fl.us/doea/pubs/pubs/2012Med_Guide.pdf

This shall be completed by

4) Your facility must provide documentation to the Miami Field Office indicating a plan for reducing the census in the facility at or below the licensed capacity. This plan must not violate the rights of any facility residents, including the right to a 45-day notice of discharge.
This plan must be submitted to the office by

Please be advised that nothing in this Directed Plan Of Correction limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact Laura Manville, Assisted Living Enforcement Team Manager at 727-552-1955 or Verlande Exil, Assisted Living Supervisor at 305-593-3151.

Date: 3/4/15
3:45pm

Barbara Clifford
AMD:ve

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

D7JR

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

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