STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966554	**05/14/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
MOUNT SINAI CHRISTIAN HOME	**5190 EAST 8 AVE HIALEAH, FL 33013**	

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

0000 - Initial Comments

A Standard Biennial survey was conducted on , 2015. Mount Sinai Christian Home had the following deficiency at time of the survey:

0052 - Medication - Assistance with Self-Admin - 58A-5.0185(3) FAC

Based on record review, observation, and interview the facility failed to ensure that 1 of 3 (A) staff member followed the steps to assistance with self-administration of medication for 1 out of 5 (#3) sampled residents.

Findings included:

Observation on at 8:30 am, Staff A assisted Resident #3 with self-administration of medication. Staff A took a cup of water and bingo card medications. Then, staff A placed all the medications from the bingo cards to a small cup and gave them to Resident #3. Staff A did not explain or tell the resident the names of the medications. Staff A also did not verify the information on MORs and did not sign the medications as given.

Record review on at 8:40 am of the medication observation records (MORs) revealed that Resident #3 had the following morning medications: 250 MG Tab, 25 MG, , DR 20 MG, 5 MG. Record review found that the MORs were not signed.

An interview with the Administrator on at 8:55 am she acknowledged that Staff A did not follow the steps to provide assistance with self-administration of medications to Resident #3.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Mount Sinai Christian Home
5190 East 8 Ave
Hialeah, FL 33013

Dear Administrator:

This letter reports the findings of a Standard Biennial licensure 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.

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

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida