STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965944	**06/18/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
MARULY'S ADULT CARE	**311 SW 136 AVE MIAMI, FL 33184**	

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

Z827 - Unlicensed Activity - 408.812, FS

Based on observations, record review, and interview, the facility failed to obtain a licensure capacity increase prior to providing personal care, meals, and assistance with medications to seven residents. The facility provided services to residents outside the current license capacity of six.

Findings included:

During the facility tour on at 5:55 AM revealed, that there were four Residents #1, #2, #3 and #5 sitting at the dining table having toast with butter and coffee with milk. Further observations showed Resident #4 was bedridden and a hospice resident. There was a the facility off the back patio with two residents (#6 and #7).
During an interview on at 6:11 AM Resident #6 stated, " this is my when I get here they put me to sleep here in this bed." She stated the food is good. We have a television here in the we can watch television. I go to bed at 7:30 to 8:00 PM. They give me my medication here, breakfast is at 8:00 AM and at night 7:30 PM or 8:00 PM, at noon I have medication before the food.

Phone interview on at 4:42 PM with Resident #6's family member, confirmed that she was a resident at the facility for a couple of months. She did not remember the dates. She stated that Resident #6 lived in an apartment in the backyard. She stated that she has not been able to visit her family member often.

Record review found an adult day care agreement for Resident #6 that stated, "the client shall be dropped off at 7:00 AM and picked up by 8:00 PM." The health assessment dated / for Resident #6 documented that she required assistance with bathing, dressing, transferring and assistance with self-administration of medications.

During an interview on at 6:25 AM, Resident #7 stated, "I'm living here for 2 months. My son moved out to New York, he left me here and this is my . I take over the counter medication and I have it here in my nightstand. My doctor comes here to see me. I had this medication in my house and I brought it here with me."
Record review found an adult day care agreement for Resident #7 that stated, "the client shall be dropped off at 7:00 AM and picked up by 5:00 PM." The health assessment dated for Resident #7 documented that she required assistance with ambulation with rolling walker, transferring, and assistance with self-administration of medications.

During an interview on at 10:36 AM, Resident #3 stated, we are six or seven persons here in this house.

During an interview on at 10:54 AM, Staff C stated, "Residents that living at the outside , they stay and sleep over at the facility sometimes, like today."

During an interview on , the facility's Consultant acknowledged there was seven residents at the facility and facility was licensed for six residents.

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Z827 Continued From page 1

Unclassified deficiency

0000 - Initial Comments

A Monitoring Survey was conducted on . Maruly's Adult Care had the following deficiencies at the time of 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 have a completed health assessment for one out of eight (#4) sampled residents.
Findings included:
Record review on showed Resident #4's health assessment Form (Form 1823) dated did not have the diet order for the hospice resident.
During an interview on at 10:10 AM, the facility's Consultant acknowledged that the health assessment did not have the diet order for Resident #4.
Class III

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

Based on observations, record review, and interview, the facility failed to honor resident rights for a safe and decent living environment free from and neglect for two out of eight (#'s 6 and 7) sampled residents. The facility failed to limit physical to half bed rails for two out of eight (#'s 3 and 4) sampled residents. The facility failed to coordinate care with hospice services for one out of eight (#4) sampled residents.

Findings included:

Upon arrival to the facility on at 5:00 AM for a monitoring survey, the survey team knocked on the door and no one answered the door. The doorbell was rang once. Another state investigator called the facility, the facility's phone rang once, but there was no one answer. The surveyor observed lights in the backyard. On at 5:24 AM, local law enforcement was contacted to gain access to the facility to ensure that the residents were safe.
On at 5:54 AM, Staff C answered the door to the facility and stated that there were only five residents in the facility. After gaining access to the facility at 5:54 AM on , observation off the back patio of the facility, through the sliding glass doors was a pathway to what appeared to be a storage " a lock. Staff C stated, this was the owner's "I do not have the keys." A few minutes after Staff C was advised that law enforcement was on their way, she later found the keys and opened the door to the storage " the patio. In the storage , two elderly women (Residents #6 and #7) were observed sleeping in two beds. The noted to be hot and a ceiling fan was observed running.

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0030 Continued From page 2

During interview on at 6:11 AM with Resident #6, she stated "When I get here they put me to sleep here in this bed."
During interview on at 6:25 AM with Resident #7, she stated while in bed, "I'm living here for two months. My son moved out to New York he left me here and this is my ."
During a phone interview on at 4:42 PM with Resident #6's family member, it was confirmed that she was a resident at the facility for a couple of months. The family member did not remember the dates. She stated, that Resident #6 lived in an apartment in the backyard. She stated, she has not been able to visit her often.

During record review it was noted, the facility's demographic sheet for Resident #6 documented, she was admitted on . The health assessment dated documented a medical history and diagnoses as ( ), , Mild , (Chronic Kidney) , , episodes, ( ), GAD, MDD, and difficulty walking. The or behavioral status was documented as disoriented and . Special precautions were documented as precautions and half bed rails. Resident #6 was documented as requiring assistance with bathing, dressing, transferring and assistance with self-administration of medications.

During record review it was noted, the facility's demographic sheet for Resident #7 documented that she was admitted on . The health assessment dated documented a medical history and diagnoses as , , , Gait , MDD, GAD, Osteoarthrits, , Vit D Deficiency, and Tremor. The or behavioral status was documented as moderate to severe , features. The special precautions was documented as precautions. Resident #7 required assistance with ambulation with a rolling walker, transferring, and assistance with self-administration of medications.

During the facility's tour on at 6:00 AM, it was observed Resident #3 and Resident #4 beds had full bed rails attached and in use.
During an interview on at 10:16 AM, Staff C stated, "her son brought the bed, but we do not have an order or consent."

During record review it was revealed, resident #4 is a hospice resident and resident #4 did not have a written physician's order from hospice for the use of full bed rails. The last physician order for Resident #4 was for half bed rails and dated . The resident's consent to the use of half bed rails was dated / /.

During a phone interview on at 10:07 AM the hospice case manager stated, "I will send a fax with the full bed rails order for Resident #4."

During an interview on at 10:10 AM, the facility's Consultant acknowledged that Resident #4's record was missing the hospice physician's orders for full bed rails and that the facility did not have a consent for the use of full bed rails.

On at 7:16 PM, another state agency representative revealed, Residents #'s 6 and 7 were removed from

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SUMMARY STATEMENT OF DEFICIENCIES
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0030 Continued From page 3

the the back patio of the facility.
On at 10:53 am interview with Staff A revealed that the facility administers medications to Resident #4 who is on hospice. She stated that Staff C primarily gives the medications the residents. Resident #4 can not hold the medications sometimes and the staff (unlicensed) put the medications in her mouth. She stated that the medications are crushed (no order found) and served with apple sauce or given to Resident #4 whole.

Class II

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

Based on interview and record review, the facility failed to ensure that staff assisted three out eight (#2 #3, and #6) sampled residents with self administration of medications within one hour of the ordered timeframe.

Findings included:

During interview on at 6:30 AM, Staff C stated, I assisted Residents #2, #3, and #6 with self-administration of medication during breakfast before 6:00 AM.

Record review on found the medication observation records (MORs) documented that Resident #2 had 8:00 AM medications of 250 milligrams (mg) one tablet for 5 days; 12 one tablet a day; 1 mg two times a day; 10 mg three times a day scheduled. Resident #3 had 8:00 AM medications of 81 mg one tablet a day; 20 mg one tablet a day; 150 mg one tablet a day and 40 mg scheduled. Resident #6 had 8:00 AM medications of 25 mg, 25 mg and 150 mg scheduled.

Class III

0057 - Medication - Over The Counter (OTC) Products - 58A-5.0185(8) FAC

Based on observations and interview, the facility failed to ensure that over the counter medications were labeled with one out of eight (#7) sampled residents' name.

Findings included:

During the facility tour on at 6:00 AM observed Residents #6 and #7 sharing a , from the facility in the backyard off the patio. Further observation showed that Resident #7 had an unlocked drawer in her nightstand with unlabeled over the counter (OTC) medications of: Anti-Diarreheal Gelatin Capsules 2 milligrams (mg), Nasal Spray (regular strength), daily , Caplets 500 mg (reducer).
During an interview on at 6:25 AM Resident #7 stated, about the medications, "I take over the counter medications that I had here with me in my nightstand."

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0057 Continued From page 4

During an interview on , the facility's Consultant acknowledged the deficiencies found regarding unlabeled OTC medications.

Class III

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

Based on record review and interview, the facility failed to ensure that the Manager did not supervise any other facilities.

Findings included:

Record review found the Administrator also supervised M.... and M..... Adult Care. The facility's Delegation of Authority letter listed two staff members in the absence of the Administrator, one of staff member no longer worked for the facility. The second person listed was Staff D, who is also the Administrator of Southwind Adult Care.

Phone interview on at 3:15 PM with both owners. They explained they were in another country and they were returning this weekend. One owner stated that Staff D was in charge and that he was going to hire another manager.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observation, record review and interview, the facility failed to ensure in the absence of the Administrator, qualified staff was responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents. The facility had 7 residents living at the facility.

Findings included:

Upon arrival to the facility on at 5:00 AM for a monitoring survey, the survey team knocked on the door and no one answered the door. The doorbell was rang once. Another state investigator called the facility, the facility's phone rang once, but there was no one answer. The surveyor observed lights in the backyard. On at 5:24AM, local law enforcement was contacted to gain access to the facility to ensure that the residents were safe.
On at 5:54 AM Staff C answered the door to the facility. Observations of the facility at the time found Staff C in the facility alone with a census of seven residents. Some of the residents were sitting at the dining having toast with butter, and coffee with milk.

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0079 Continued From page 5

Observation of the facility on [redacted] at 6:11 AM found, seven residents in the facility which included Residents #6 and #7 who were living in a [redacted]/storage area off the back patio of the facility. It was noted, the location where residents #6 and #7 were living was not part of the licensed assisted living facility. The [redacted]/storage area was attached to the covered patio. The storage area had three containers of gas cans, two mattresses, a bike, a rollaway bed, a ladder, empty shopping carts, a freezer, and multiple refrigerators were observed in the area where two residents were residing. There was a yellow sign posted on the wall next to the entrance to the storage area that read, "Posted private property hunting, fishing, trapping or trespassing for any purpose is strictly forbidden violator will be prosecuted," and the owner's contact information was listed. The door that lead to Resident #6 and #7's [redacted], "Private."

On [redacted] at 7:16 PM, another state agency representative revealed, Residents #'s 6 and 7 were removed from the [redacted] the back patio of the facility.

During the review of the facility's Delegation of Authority letter, it was noted that it listed two staff members to be in authority in the absence of the Administrator. The staff scheduled to work at the facility for the month of [redacted] 2015 showed, the Administrator, the Manager (listed on the delegation letter), and Staff C. The staff schedule was noted to for the month of [redacted] 2015, but it did not have specific dates for the staff to work, the schedule documented the following: The Administrator, who is also the Administrator of two other Assisted Living Facilities(ALF) (M..... and M..... Adult Care) was scheduled to work from 8 PM to 7 AM Thursday's to Tuesday's. The Manager, who is also the Administrator of another ALF (S.... Adult Care) was scheduled to work from 12 PM to 8 PM, Sunday's to Friday's. Staff A was not listed on the Schedule, and Staff C was scheduled to work from 7 AM to 4 PM Wednesday's to Monday's. The staff schedule had a fourth person listed, but the facility did not provide a personnel record for that person and it is unclear of their employment status.

The facility is required to have 212 hours per week for a census of seven residents. The facility did not have time sheets available to review or any verification of staffing hours other than the posted staff schedule. Staff A provided a written record of her staff hours, which totaled 53 hours per week and Staff C provided a written record of her staff hours, which totaled 51 hours per week. The total hours for both employees was 104 hours for the week. Staff C also documented that she had been working in the facility from [redacted] at 10 PM to the day of the survey without any relief.

Record review of Staff A's training certificates revealed they did not have the employee's required signature for:
Understanding elopement policy and procedures,
Resident rights and reporting [redacted], neglect, and
Resident behavior, needs, and assistance with ADL's
Reporting major incidents and facility emergency procedures
and safe food handling practices

On [redacted] at 7:13 AM, the facility's Consultant arrived at the facility. She stated, the Manager is the sister of the

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0079 Continued From page 6

owner and he's/the owner is not here.
On at 7:24 AM phone interview with the owner revealed, he has three facilities with licenses. He stated, he is on vacation 12 hours away from here.
During the monitoring survey on it was revealed, the facility did not have a person in charge in the absence of the Administrator. The designated Manager was unable to communicate with the surveyors during the survey because she had an unlicensed investigation in progress at another location.

On at 10:51 AM, Staff A and C stated there was no staff coverage for tonight but one of them was going to stay with the residents.

Observations of the facility on from 10:45 AM to 11:00 AM found, the facility staff were not preparing lunch for the residents. The last meal observed was before 6 AM, when residents were having toast with butter and coffee.

On at 10:54 AM Staff C stated, we do not cook at the facility. She stated, the residents food was catered, but she did not have a catering food contract information and reported, the owner is the one that takes care of this.
During a phone interview on at 12:51 PM with Staff C regarding whether the residents were feed lunch, she stated, the owner is the person that cooked the food at the facility, but now because he is out on vacation, he ordered the food from another ALF. She stated, I don't know which ALF the owner made that arrangement with.
During the second visit to the facility on at 2:45 PM to verify that residents were served lunch.
Observations found, three small re-used ice cream containers with mixed vegetables, spaghetti with cut up meat which appeared to be hotdogs, and noodles also with diced meat which appeared to be hotdogs.
Staff C stated to surveyor and the another state agency investigator that someone dropped off the food to the facility, and she did not know who the person was or where they came from.
During a phone interview on at 3:15 PM with both owners. They explained they were in another country and they were returning this weekend. One of the owners stated, Staff D was in charge, but confirmed staff D was not present during the survey. The owner stated, he was upset about the food and this was not what was planned for the residents food.

On , the Agency for Health Care Administrator requested a plan of correction from the facility. The directed corrective actions included:

1. The Assisted Living Facility is required to submit a plan to the Agency by 5:00 PM on , 2015, indicating how the facility will come into compliance with the facility's licensed capacity of six beds
2. The Assisted Living Facility is required to submit a staffing schedule by 5:00 PM on , 2015 detailing which qualified staff will be available to provide care and services through , 2015.
3. The Assisted Living Facility is required to provide written documentation of a qualified manager or designee providing oversight to the field office in the absence of the administrator to the Area 11 field office by 5:00 PM 19, 2015.
4. The Assisted Living Facility is required to provide a written plan outlining the facility's actions to ensure the

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0079 Continued From page 7

provision of three meals a days plus a snack with less than 14 hours between dinner and breakfast.

As of , the agency has not received any documentation from the facility.

Class II

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

Based on observation and record review the facility failed to follow the menu and note substitutions on or before the meal was served.

Findings included:

On at 5:54 AM observed some of the residents sitting at the dining having toast with butter, and coffee with milk.

During the second visit to the facility on at 2:45 PM to verify that residents were served lunch.
Observations found, three small re-used ice cream containers with mixed vegetables, spaghetti with cut up meat which appeared to be hotdogs, and noodles also with diced meat which appeared to be hotdogs.
Record review found the facility did not follow the posted menu for breakfast and lunch; also there were no substitutions noted on the menu.
Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on observations, record review, and interview, the facility failed to have an up to date admission and discharge log. The facility also failed have a current fire inspection.

Findings included:

Record review found the facility's admission and discharge log did not included Residents #6 and #7.

Interview on at 6:11 AM with Resident #6, she stated, "When I get here they put me to sleep here in this bed."
Interview on at 6:25 AM with Resident #7, she stated while in bed, "I'm living here for two months. My son moved out to New York he left me here and this is my ."

Observations on after 6 AM found the fire inspection was not posted on the bulletin with the other documents.

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Record review found the facility did not have a fire inspection available for review.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Maruly's Adult Care
311 Sw 136 Ave
Miami, FL 33184

Dear Administrator:

This letter reports the findings of a Monitoring 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.

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

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RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Maruly's Adult Care
311 SW 136 Ave
Miami, FL 33184

Dear Administrator:

This letter reports the findings of a Complaint inspection survey conducted on , 2015, by representatives of the Agency for Health Care Administration Agency. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) immediately.

The inspection resulted in findings of non-compliance in the following areas:
St - A - 0079 - 58a-5.019(3) Fac - Staffing Standards - Levels
St - A - 0092 - 58a-5.020(1) Fac - Food Service - General Responsibilities
St - A - Z827 - 408.812, Fs - Unlicensed Activity

Directed Corrective Actions:
1. The Assisted Living Facility is required to submit a plan to the Agency by 5:00 PM on 19, 2015, indicating how the facility will come into compliance with the facility's licensed capacity of six beds
2. The Assisted Living Facility is required to submit a staffing schedule by 5:00 PM on 19, 2015 detailing which qualified staff will be available to provide care and services through , 3015.
3. The Assisted Living Facility is required to provide written documentation of a qualified manager or designee providing oversight to the field office in the absence of the administrator to Area 11 the field office by 5:00 PM , 2015.
4. The Assisted Living Facility is required to provide a written plan outlining the facility's actions to ensure the provision of three meals a days plus a snack with less than 14 hours between dinner and breakfast.

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

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Should you have any questions, please contact . Laura Manville, Survey and Certification Support Branch, at (727) 552-1955 Kristal Branton, Health Facility Evaluator Supervisor, Miami 11, (305) 593-3106

Arlene Mayo-Davis, RN
Field Office Manager

AMD:kb

6/18/15 3:01pm

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