AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966998	**03/02/2016**
NAME OF PROVIDER OR SUPPLIER **ARMERO TORRES ALF, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **3011 NW 52 STREET MIAMI, FL 33142**	

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

0000 Initial Comments

A Monitoring survey was conducted on at Armero Torres ALF Inc. The following deficiencies were identified at the time of the survey.

0008 Admissions - Health Assessment

Based on record review and interview, the facility failed to have an updated AHCA form 1823 Health Assessment or a doctors order stating that the Resident was able to self-administer her own shots.

Findings included:

On at approximately 12:00 pm, the Administrator stated that she had been preparing the resident's and the resident had been self-administering it.

On at 2:00 PM, Resident #4stated that she has been injecting herself since living at the facility from to the present 03-02- 2016.

Resident #4's form 1823 Health Assessment dated - revealed that the resident needed assistance with the self administration of medication.

A review of Resident #4's chart showed that there was not a doctor's order stating that the resident was able to self-administer her at the time of the survey.

Class III

0052 Medication - Assistance with Self-Admin

Based on interview and record review facility failed to have a Registered Nurse in the facility to assist one of six residents (Resident #4)with preparing and assisting with injections during the day and evenings hours.

Findings included:

On at 1:00 PM, Resident #4 stated that she is given her medations during the day and evening hours by the Administrator. Resident #4 also stated that she also takes her own sugar level

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before taking the injections. The resident further stated that after every injection of the injections are completed, she would give the injection needle back to the Administrator. Resident (#4) stated that the Administrator has always prepared the in a needle for her and would bring the injector to the (#4) where the resident would apply the injection of the on her own without the assistance of the Administrator. The Resident #4 stated that she has been doing this ever since being admitted to facility on .

A review of the Medication Observation Record (MOR) showed that 100 UNIT/ML VIAL was scheduledto be taken at 7am, 1pm, and 7pm. Further review of the MOR showed that medication 100 UNITS/ML VIAL was scheduled to be taken at 7:00 PM.

A review of AHCA Form 1823 Health Assessment dated revealed that Resident #4 needs assistance with self-administration of medications, which this allows unlicensed staff to assist with oral and medications.

A review of the Administrator's personnel file revealed that the Administrator is not a nurse or other medical provider licensed to administer medication.

On at 2:00 pm, the Administrator stated that Resident #4 had always been injecting herself with her and had a doctor's order to do so. She further stated that she would have the doctor send her a copy, and that she would place it in the residents chart.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Armero Torres Alf, Inc
3011 Nw 52 Street
Miami, FL 33142

Dear Administrator:

This letter reports the findings of a monitoring state licensure survey that was conducted on , 2016 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 Sonia Bailey, Health Facility Evaluator Supervisor, at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure
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