STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967271	04/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING	**11401 SW 42 TERRACE MIAMI, FL 33165**

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

0000 Initial Comments

A Standard Biennial Survey was conducted on . Premier Assisted Living had deficiencies found at the time of survey.

0010 Admissions - Continued Residency

Based on observation, record review, and interview the facility failed to ensure that one out of six(#1) sample residents met continued residency criteria. The facility failed to updated health assessment for one out of six (#1) residents sampled who had changes in activities of daily living (ADLs) levels.
Findings included:
Observation on at 9:00 AM in # I found Resident #1 lying down in a chair. The resident was observed to have contracted hands and legs. Further observations on at 12:00 PM found Staff B (caregiver) going into Resident #1's . Staff B placed the chair in sitting position, Resident #1 unable to uncross her legs. Resident #1 required total assistance from Staff B with the transferring, Staff B carried Resident #1.
Record review showed Resident #1's health assessment (AHCA form 1823) stated the resident needed assistance with ambulation, bathing, dressing, toileting, transferring and supervision with eating and self care.
During and interview on / at at 10:39 AM Staff B (caregiver) stated that Resident #1 needed a total assistance with all ADLs. She stated Resident #1 could not walk and could not transfer.
During the exit interview on at 2:20 PM the facility's Administrator stated that Resident #1 have her days. She stated that sometimes she is . She stated today she is not helping much but this is not happening every day.
Class III

0053 Medication - Administration

Based on observation, record review, and interview the facility failed to ensure that only licensed personnel administered crush medications to one out of six (#1) sampled residents.
Findings included:
Observations on at 12:00 PM, Staff B (caregiver) crushed medication pill, pour the powdered medication on the side of Resident #1's plate. Staff B mixed the food with medication and fed it Resident #1.
Record review on showed Resident #1's health assessment (AHCA form 1823) dated / specified that the resident needed assistance with self-administration of medication.
During an interview at 12:30 PM, Staff B stated that she is not a nurse.
During an interview on at 2:20 PM, the facility's Administrator stated staff did crush medication

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for Resident #1. She stated we have the order to crush her medication. The facility's Administrator acknowledged that medication was administered to Resident #1 by unlicensed personnel.
Class III

0093 Food Service - Dietary Standards

Base on observation, record review and interview the facility failed to offer a therapeutic diets prepared and served as ordered by the health care provider for one out of six (#1) sampled residents.
Findings included:
Lunch observations on at 12:00 PM found the facility's staff fed Resident a plate of regular food.
Record review on showed Resident #1 had a physician's order for pureed diet and thicken liquids; diagnosis:
During an interview on at 12:00 PM, Staff B (caregiver) stated Resident #1 did have a puree diet but sometime we give regular food. She stated we give regular food to her when we consider that she can eat it.
During an interview on at 2:20 PM, the facility's Administrator stated we have a pureed diet order by a physician for Resident #1 but this is only if we consider that she can't not eat the regular food. She stated we evaluate if she can eat or not the regular food.
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Premier Assisted Living
11401 Sw 42 Terrace
Miami, FL 33165

Dear Administrator:

This letter reports the findings of a Standard Biennial 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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

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