STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967365	07/21/2016
NAME OF PROVIDER OR SUPPLIER **ALL USA HOME, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **4214 SW 3 STREET** **MIAMI, FL 33134**	

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

0000 Initial Comments

A Standard Biennial survey was conducted on / . All USA Home.Inc Assisted Living Facility Home (lic #11431) had the following deficiencies found at the time of the survey:

0008 Admissions - Health Assessment

Based on observation, record review and interview, he facility failed to ensure that an accurate and current comprehensive health assessment (AHCA form 1823) was properly completed for one out of five (#1) sampled residents.
Findings included:
Observation on / at 8:05 AM during the facility tour Resident #1 ' sat on her bed. Furthermore observe Resident #1 ' transferring independent with walker assistance.
Record review on / showed that Resident #1 ' (admitted on /) health assessment (AHCA form 1823) dated / in Section 1: activities of daily living Resident #1 ' needed total assistance with bathing and transferring.
On / at 11:27 AM Resident #1 ' stated "I walked in the facility from my the living , to the porch with my walker."
On / at 10:00 AM, the Administrator acknowledged that health assessment ws not accurate. He stated "She came here almost without walking but I helped her with that a lot and she is walking."
Class III

0030 Resident Care - Riahts & Facilitv Procedures

Based on observation, record and interview, the facility failed to obtain a written physician's order for use of a half-bed rail for two out of five (#1 and #2) sampled residents.
Findings included:
Observation on / at 8:05 AM during the facility tour Resident #1 sat in on her bed in #. The bed had an attached a half bed rail.Also observed in # Resident #2 's bed with half bed rail attached.
Record review showed that Resident #1 (admitted on /) did not have physician's order for the use of half bed rail. Further record review showed that Resident #2 's (admitted on / /) physician order to the use of half bed rail on record was dated . Resident #2 's record did not have updated physician order for review.
On / at 10:00 AM, the Administrator acknowledged that record for Resident #1 did not have aphysician's order to the use of half bed rails. He stated "she is enrolled in a clinic and you know how difficult to deal with doctors." He also acknowledged that Resident #2 's physician order for the use of half bed rails was expired.

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Class III

0052 Medication - Assistance with Self-Admin

Based on observation, record review and interview, the Assisted Living Facility 's staff failed to follow procedures during assistance with self-administration of medication for three out of five (#1, #2 and #3) sampled residents.
Findings included:
During an observation on / at 11:58AM PM, Facility Staff B unlocked the medication cabinet, wearing gloves. Staff took the plastic box with the medication card for Resident #4 ' . Staff B punched the medication from the card into a plastic cup and dropped the pill (100 mg) into Resident #4's hands. Staff did not identify the medication by name to the resident. Resident #4 swallowed the medication with water and Staff did not initial medication observation record (MOR). Further observation showed at 12:00 PM Staff B unlocked medication cabinet, Staff wears gloves. Staff took plastic box with medication card for Resident # 3 ' . Staff B punched the medication from the card into a plastic cup and dropped the pill (Sucralfate 1GM) into Resident #3 ' hands. Staff did not identify the medication by name to the resident. Resident #3 swallowed the medication with water. Staff B did not initial MORs. Staff B assisting resident #1 with self-administration of medication at 12:04 PM showed that Staff B unlocked medication cabinet, wearing gloves. Staff B (caregiver) took plastic box with the medication card for. Staff did punch medication card into a plastic cup and dropped the pill (- ER 25-100 MG and 1 mg) into Resident #1 's hands. Staff did not identify the medication by name to resident. Resident did swallow the medication with water. Staff did not initial the MOR.
Record review on / at 12:10 PM requested medication observation record (MOR ' s) showed that noon (12:00 Pm) medication was not initialed by staff.
During an interview on / at 12:10 PM the facility Staff B (caregiver) stated " I have to sign for medication now " . She stated can I sign now?
During an interview on / at 12:14 PM stated from the kitchen to Staff B "you need to tell medication name to residents and you needed to initial MOR."
Class III

0078 Staffing Standards - Staff

Based on observation, record review and interview the facility failed to have evidence of a negative examination on an annual basis for three out of three (administrator, B and C) staff.
Findings included:
On / at 10:00 AM , observed Staff B preparing daily food for residents at 12:00 PM was observing facility administrator serving lunch for residents.
Record review on / showed that facility staff personnel records Administrator (hire on)

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communicable and freedom for documentation was dated . Staff B hired on communicable and freedom for documentation was dated and Staff C hired on communicable and freedom for documentation was dated .

During an interview on at 9:10 AM, the facility administrator stated " I have not updated documentation for the test and communicable for our staff " .

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
All Usa Home, Inc
4214 Sw 3 Street
Miami, FL 33134

Dear Administrator:

This letter reports the findings of a 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
XG90

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