STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966294	**07/25/2016**
NAME OF PROVIDER OR SUPPLIER **DIANA HOME CARE II**	STREET ADDRESS, CITY, STATE, ZIP CODE **1725 SW 71 COURT MIAMI, FL 33144**	

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

0000 Initial Comments

An abbreviated Biennial survey was conducted on . Diana Home Care II with Standard license (AL 10533) had the following deficiencies at the time of the visit:

0010 Admissions - Continued Residency

Based on observation, record review and interview the facility failed to ensure the appropriateness of continued residency for 2 out of 6 (Residents #5 and #6) residents.

Findings as follow:

On at 7:50 a.m. Staff D (caretaker) was observed assisting Resident #5 to transfer from the bath to the Florida a wheelchair. Then, Staff D took resident #5 under arms and asked resident to wake up from the chair, The resident did not move, and Staff D had to lift the resident, turn her and sit her in the coach. The resident did not assist in the process.
On at 8:15 a.m. observed Staff D assisting Resident #6 to transfer in a wheelchair, from bath to a couch .

On at 8:00 a.m. Staff C (caretaker) was observed giving food to Resident #5 directly from plate to her mouth. The resident did not assist in the process.
On at 8:20 Staff C was observed giving food to Resident #6, directly from the plate to her mouth. The resident did not assist in the process.
Record review showed Resident #5's health assessment dated states: and behavioral status: Wheelchair bound. Resident #5 needs total assistance with ambulation, bathing, dressing, toileting. The assessment further stated that the resident needed assistance with eating and self care and transfering.
Record review showed Resident #6's health assessment dated states: : HBP, s , OA. and behavioral status: Memory, concentration. Resident needs: Assistance with all the activities of daily living. Assistance with self- administration of medications.
On at 8:50 a.m. the facility assistant administrator acknowledged Residents #5 and #6 needed total assistance with transfering and eating , and stated that a new assessment evaluating the residents' conditions is needed.

Class III

0084 Trainina - Assis Self-Admin Meds & Med Mamt

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SUMMARY STATEMENT OF DEFICIENCIES
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Based on record review and interview the facility failed to have documentation confirming that 2 of 4 (Staff A and B) staff responsible for assisting residents with self administration of medications were trained as required by statute.

Findings as follow:

Record review showed the medication training for Staff A (administrator) and Staff B (assistant administrator) dated was signed but did not have the credentials of the trainer.
On at 11:20 a.m. the Administrator and Assistant Administrator acknowledged the medication training certificate was not valid.

Class III

0125 Fiscal - Surety Bonds

Based on interview and record review the facility failed to have a surety bond while acting a representative payee for 1 out of 6 (Res #1) residents.

Findings:

On at 11:11 a.m. the Administrator stated the payments from Resident #1 go directly to the facility's bank account. She further stated that the facility had no a surety bond.

Record review showed the Contract between the facility and Resident #1 dated / / states resident has to pay a monthly sum of $963.00.

A review of the facility records showed that the facility had no a Surety bond.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Diana Home Care Ii
1725 Sw 71 Court
Miami, FL 33144

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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