STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911830	08/02/2016
NAME OF PROVIDER OR SUPPLIER **ALF MANAGEMENT AND PROFESSIONAL SERVICES,**	STREET ADDRESS, CITY, STATE, ZIP CODE **21 SW 75 AVENUE** **MIAMI, FL 33144**	

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

0000 Initial Comments

A Standard Biennial Survey was conducted on / . ALF Management and Professional Service Inc (license # 5902) had the following deficiencies found at time of the survey:

0010 Admissions - Continued Residency

Based on observation, record review, and interview the facility failed to have an accurate health assessment by a health care provider professional for one of thirteen (#2) sampled residents.
Findings included:
Observations on / during survey at 8:30 AM showed that Resident #2 was sitting in the family a chair.
Record review showed Resident #2's (admitted on / /) health assessment form 1823 dated / / did not specify what assistance the resident needs with medication (blank). Further review showed Resident #2 was bedbound and received hospice services and needed total assistance with all activities of daily living (ADLs). Resident #2 had a physician's order dated stipulating " all medication needs to be crushed".
During an interview on at 11:14 AM, facility Administrator stated that staff crushes Resident #2's medication and administers to resident #2. He stated that the resident was not able to self-administer her own medication. He acknowledged that health assessment did not specify what assistance Resident #2 needed with her medication.
Class III

0053 Medication - Administration

Based on observation, record review and interview, the Assisted Living Facility failed to ensure that only licensed personnel administered crush medications for one out of 13 (#2) out 13 sampled residents.
Findings included:
Observation on during survey at 8:30 AM showed that Resident #2 was seating in a family a chair.
Record review on / showed Resident #1 ' s (admitted on / /) health assessment form 1823 dated / / did not specify what assistance resident needs with medication (blank). Furthermore Resident #1 was bedbound and received hospice services and needed total assistances with all activities of daily living (ADLs).
During an interview on / at 11:07 AM Staff B (caregiver) stated that she did administer medication to Hospice Resident #2. She stated "I mixed medication with puree or apple sausage and I fed her with spoon." She further stated "I ' m not a nurse."
During an interview on / at 11:14 AM, facility Administrator acknowledged the deficiencies found.

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He stated that staffs crushed her medication and administered to resident #2. He stated that she is not able to self-administration of medication. He acknowledged that thehealth assessment did not specify what assistance the resident needed with her medication.
Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation and interview, the facility failed to provide a safe and clean living environment to facility residents.
Findings Included:
During the facility tour on / at 8:38 AM showed that facility between # and the employee a yellow substance and black spots on the ceiling.
During the exit conference on / at 2:00 PM, the facility Administrator acknowledged the deficiencies. He stated that ceiling was repaired and need to be painted.
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Alf Management And Professional Services, Inc
21 Sw 75 Avenue
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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