RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

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

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2016by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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. Should you have any questions please call this office at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure

BBT7

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone:(305) 593-3100; Fax:(305) 593-3121
AHCA.MyFlorida.com

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966294	R
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 Revisit Survey was conducted on 09/22/16. Diana Home Care II with Standard license (AL 10533) had the following deficiencies at the time of the survey:

0010 Admissions - Continued Residency

Based on observation, interview, and record review the facility failed to have an updated health assessment for two out of six (Resident #5 and 6) sampled residents.
Findings included:
On at 12:22 pm, observed Staff C assist Resident #5 ' with self-administration of medication. Staff C unlocked medication cabinet, took the medication card, walked to the recliner chair punched medications into a plastic cup and read medications names to Resident #5 ' (37.5-325). Staff C then put the plastic cup onto Resident #5 ' mouth and poured the tablet into the resident's mouth . Observed Resident #5 ' was not able to hold the cup with her own hands.
On at 12:25 PM, Staff C stated "I did assist Hospice Residents with self-administration of medication on Tuesday, Thursday and Sunday. I ' m not a nurse. I assisted all hospice residents the same way that I did now to her (Resident #5 ')."
Record review showed the following: Resident #5 's (admitted on) health assessment (AHCA form 1823) dated showed that resident need total assistance with activities of daily living (ADLs '), Ambulation (wheelchair), bathing, Dressing, Eating (ALF) preparation of meals and tray set up, self-care, toileting, transferring. On Section 2-B: does the individual need help with taking his medications was (blank). Resident#5 ' needed assistance with self-administration of medications. Resident was admitted on hospice on and her Plan of care showed that the resident needed a puree diet, aid with feeding.
Resident #6 's (admitted on) health assessment (AHCA form 1823) dated showed that resident need total assistance with all ADL ' s. Special diet: Puree. On Section 2-B: does the individual need helped with taking his medications " able to administer w/o assistance " additional comments/ Observations under Hospice Care. Resident was admitted on hospice on , with a plan of care/summary of nursing visit dated . Resident was bed bound and was found sitting in reclining chair, alert but disoriented to time and place . Plan of care dated showed that " medications to be administered by: ALF staff "
During an interview on at 1:31 PM the Administrator acknowledged that health assessment was not accurate because both hospice Residents #5 and #6 were not able to self-administer their medications. She stated staff administers medications to all hospice residents.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966294	R
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)

0053 Medication - Administration

Based on observation and interview, the Assisted Living Facility failed to ensure that only licensed personnel administered medication for two out of six (#5 and #6) sampled residents.
Findings included:
On at 12:22 Pm, observed Staff C assist Resident #5 ' with self-administration of medication. Staff C unlocked medication cabinet, took the medication card, walked to the recliner chair punched medications into a plastic cup and read medications names to Resident #5 ' (37.5-325). Staff C then put the plastic cup onto Resident #5 ' mouth and poured the tablet into the resident's mouth . Observed Resident #5 ' was not able to hold the cup with her own hands.
On / at 12:25 PM, Staff C (caregiver) stated "I did assist Hospice Residents with self-administration of medication on Tuesday, Thursday and Sunday. I ' m not a nurse. I assisted all hospice residents the same way that I did now to her (Resident #5 ')."
During an interview on at 1:31 PM the Administrator acknowledged that health assessment was not accurate because both hospice Residents #5 and #6 were not able to self-administer their medications. She stated staff administers medications to all hospice residents

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11966294 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DIANA HOME CARE II	1725 SW 71 COURT MIAMI, FL 33144

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0084 Reg. # 58A-5.0191(5) FAC LSC	Correction Completed	ID Prefix A0125 Reg. # 429.27(2) FS; 58A-5.021(3) FAC LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE 10/11/16	TITLE HFES	DATE
FOLLOWUP TO SURVEY COMPLETED ON 7/25/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: 10AC12