STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968667	R 11/14/2016
NAME OF PROVIDER OR SUPPLIER **M TRIANAS ALF, CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **9024 SW 21 TERRACE** **MIAMI, FL 33165**	

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

0000 Initial Comments

A Standard Biennial Revisit was conducted on 01, 2016 and concluded on 14, 2016. M Trianas ALF, Corp had deficiencies identified at time of the survey.

0052 Medication - Assistance with Self-Admin

Based on observation and interview the facility failed to follow appropriate procedure when assisting three out of four (#2, 3, and 4) sampled residents with self- administration medication.

Findings included:

Observations on / / at 7:00 PM found all the residents in bed.

Record review of medication record showed the medication for 8 PM was initialed by care staff using the initials prior to 7:00 PM.

Interview on / at 7:05 PM with the Administrator via phone stated, "The nurse is coming to give the medications." then stated, at 8:10 PM stated, "The nurse came right before I arrived to give the medications"

Uncorrected Class III

0053 Medication - Administration

Based on observations, record review, and interview the facility failed to ensure a licensed professional is able to administer medication to one out of four sampled residents (#2).

Finding included:

Observations on / at 7:00 PM found all the residents in bed.

Record review of medication record showed the medication for 8 PM was initialed by care staff using the initials prior to 7:00 PM.

The facility records contained no documentation that there was a nurse administering medication to Resident #2. The facility no proof they contracted or employed a nurse to provide these services for Resident #2.

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

Interview on 11/14/15 at 8:10 PM with the Administrator stated, "I do not have the nurse's license here. It is at my house. The son gave us permission to give the medications."

Class III

0077 Staffing Standards - Administrators

Based on observation and interview, the facility failed to be under the supervision of an administrator.

Finding included:

Observation on / at 7:00 PM found four residents at the facility in bed. Staff B and C were in care of the residents.

The Administrator was not available during the survey. The owner who is not CORE trained arrived to the facility at 7:58 PM on / .

Interview with the owner on / / at 7:00 PM stated the Administrator does not work tonight.

Uncorrected Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11968667 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
M TRIANAS ALF, CORP	9024 SW 21 TERRACE MIAMI, FL 33165

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 A0152 Reg. # 58A-5.023(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
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) O	DATE 8/11/15/14	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/22/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
M Trianas Alf, Corp
9024 Sw 21 Terrace
Miami, FL 33165

Dear Administrator:

This letter reports the findings of a Standard Biennial revisit survey concluded 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:ve
Enclosure

BBT7

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