RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Maggie's Retirement Home #4
7100 Nw 1 Terrace
Miami, FL 33126

Dear Administrator:

This letter reports the findings of a standard biennial 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

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

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GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Maggie's Retirement Home #4
7100 Nw 1 Terrace
Miami, FL 33126

Dear Administrator:

This letter reports the findings of a biennial inspection survey conducted on 16-17, 2016, by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0008 - 429.26(4-6) Fs; 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0010 - 429.26(1&9) Fs; 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0025 - 429.26(7) Fs; 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0052 - 58a-5.0185 (3) - Medication - Assistance With Self-Admin S-S= G
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0079 - 58a-5.019(3) Fac - Staffing Standards - Levels S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0160 - 58a-5.024(1) Fac - Records - Facility S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D
St - C - Z816 - 408.809(2)(a-C) Fs - Background Screening-Compliance Attestation S-S= C

Directed Corrective Actions:

1. The Assisted Living Facility is required to document that all staff who are administering or assisting with self-administration of medication to residents have been re-trained on correct medication practices by a licensed pharmacist or registered nurse. Documentation of this training, including the training agenda and a sign-in sheet, must be kept on file at the facility for review by the Agency.
2. The Assisted Living Facility is required to document that all residents needing sugar level or any vital signs like or pulse prior taking medication have been done and kept on record in resident files. A list of residents receiving these services must be kept on file at the facility and available for review by the Agency.
3. The Assisted Living Facility is required to have a registered nurse review Medication Observation Records prior the beginning of the month to ensure medicines match the

Medication Observation Records, and ensure that Medication Observation Records include the name of the resident and any known [illegible] the resident may have; the name of the resident ' s health care provider, the health care provider ' s telephone number; the name, strength, and directions for use of each medication.

These tasks must be completed by [illegible], 2016.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact [illegible] Sonia Bailey, Health Facility Evaluator Supervisor, Miami Field Office, (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb

D7JR

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11912063	**11/16/2016**
NAME OF PROVIDER OR SUPPLIER **MAGGIE'S RETIREMENT HOME #4**	STREET ADDRESS, CITY, STATE, ZIP CODE **7100 NW 1 TERRACE MIAMI, FL 33126**	

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

0000 - Initial Comments

A Standard Biennial Survey was conducted on 16th, 2016 and 17th, 2016. Maggie's Retirement Home #4 with limited mental health and extended congregate care components and license number 7978 had the following deficiencies identified at the time of the survey:

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview, the Assisted Living Facility failed to ensure that health assessment (AHCA form 1823) completed within 60 calendar days before to resident's admission to a facility or within 30 calendar days of the admission date for one (#12) out of 12 sampled residents.

Findings included:

Review of Resident #12's record revealed that Resident #12's admission date was on . There was no health assessment (AHCA form 1823) for Resident #12 in record at the time of the survey.

On / / at 1:01 PM , observed that Caregiver C found one page of Resident #12's health assessment (AHCA form 1823). A review of the page showed that it d not have Resident #12's diagnoses, list of current medications prescribed, if the resident will require any assistance with the administration of medication, date of the examination, and the name, signature, address, telephone number, and license number of the examining health care provider.

In interview / / at 1:02 PM the Caregiver C stated "I didn't find it."

Class III

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, interview and record review, the Assisted Living Facility failed to ensure the appropriateness ofcontinued residency for one (Resident #3) out of s12 sampled residents. Facility failed to obtain

Findings included:

Observation on / / at 11:50 AM revealed that Resident #3 sat on the sofa in the Florida Caregiver D sat next to Resident #3 with a plate with puree food in the hand. Caregiver D put spoon with puree food inside Resident #3 ' s mouth.
In an interview on / / at 11:50 AM the Caregiver D stated " I removed her because her gums

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SUMMARY STATEMENT OF DEFICIENCIES
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were
Review of Resident #3's record revealed that Health assessment (AHCA form 1823) completed on / / showed that Resident #3 needed assistant with all activities of daily living (ambulation, bathing, dressing, eating, self-care, toileting, transferring); special diet instructions: regular, puree.
In an interview on / / at 12:20 PM the Caregiver C revealed that the health assessment for Resident #3 was the more updated.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on interview and record review, the Assisted Living Facility failed to maintain an updated written record with any significant changes that resulted in medical attention for one (#6) out of 12 sampled residents.

Findings included:

In an interview on / at 9:25 AM in # Resident #6 revealed that Resident #6 went to the dentist the day before and Resident #6 had surgery in the mouth and had six . Resident #6's son and granddaughters went with Resident #6 to the dentist.

Review of Resident #6's record revealed that there was no written documentation that showed Resident #6 went to dentist on / , had the surgical procedure and returned with a doctor's order for treatment.

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation, record review and interview, the Assisted Living Facility's caregiver failed to follow procedures identified by rule and statute during assistance with self-administration of medication placing two (#6 and #1) out of 12 sampled residents in a situation that lead to a direct threat to their health. Resident #6 received a medication that was not prescribed for her, placing her at risk of an reaction. The facility's caregiver failed to check with one (resident #6) out of twelve sampled residents for their sugar/glucose level to ensure it met the parameters before the resident took the medication.

Findings included:

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

Observation on 11/16/16 at 7:34 AM revealed that Caregiver B went to the medication cabinet unlocked it, took the medication card out of the medication cabinet and left the medication cabinet open. Caregiver B went to # , took a tablet out of the medication card, placed it directly into her hand and Caregiver B put the medication tablet in Resident #6's mouth.
Review on / / at 7:36 AM of the medication card used by Caregiver B during medication administration to Resident #6 revealed, it was labeled with Resident #1's name and the instructions showed -Trimethoprim 800-160 mg take one tablet by mouth every twelve hours for seven days. According to Mayo Clinic, the medication - 800-160 mg is an used to treat . This medicine may cause serious reactions like which can be life-threatening and requires immediate medical attention.

Review of Caregiver B's personnel record revealed, Caregiver B was an unlicensed caregiver. An unlicensed caregiver administered the medication to resident #6. Resident #6 received a medication that was not prescribed for resident #6, placing resident #6 at risk of an reaction.
Review of Resident #1's Medication Observation Record (MOR) on / at 7:40 AM revealed, the order for - 800-160 mg take one tablet by mouth every twelve hours for seven days was not written on Resident #1's MORs.
Review of Resident #6's MORs on / / at 7:43 AM revealed, the order for - 800-160 mg, take one tablet by mouth every twelve hours for seven days was not written on Resident #6's MOR. Resident #6's MOR had a blank space next to , also it did not include Resident #6's physician name nor telephone number. There were no medications documented in Resident #6's MORs. Resident #6's MORs included:
- 25 mg- take one tablet daily- scheduled at 8 AM
- 25 mg - take one tablet daily- scheduled at 8 AM
- Vit D2 50,000 unit- take one tablet weekly- scheduled at 8 AM / , / / , / / , and / /
- 1 mg - take one tablet daily- scheduled at 8 AM
- 20 mg- take one tablet daily- scheduled at 8 AM
- HBr 20 mg- take one tablet daily with breakfast- scheduled at 8 AM
- 25 mg - take one tablet at bed time- scheduled at 8 PM
- 200 mg - take one tablet twice a day- scheduled at 8 AM and 8 PM
- 12.5 mg- take one tablet twice a day as needed- scheduled at 8 AM and 8 PM
- 10 mg - take one tablet at bed time- scheduled at 8 PM
- 500 mg - take half a tablet daily if sugar is less than 100 do not take it- scheduled at 8 AM.

The following medications were not initialed as given on / / at 8 PM:
- 25 mg

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MAGGIE'S RETIREMENT HOME #4	**7100 NW 1 TERRACE MIAMI, FL 33126**

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

- 200 mg
- 12.5 mg
- 10 mg

The following medications were not initialed as given on / / at 8 AM:

- 25 mg
- 25 mg
- 1 mg
- 20 mg
- HBr 20 mg
- 200 mg
- 12.5 mg
- 500 mg

In an interview on / / at 7:40 AM, Caregiver B revealed that all residents took their morning medications.

In an interview on / / at 7:50 AM, Caregiver B stated, "I gave medicines last night but I always sign them the next day in the morning."

In an interview on / / at 8:53 AM, Caregiver B revealed, Resident #6's doctor ordered the same to Resident #6 that the one prescribed for Resident #1 but the facility has not received Resident #6's medication.

In an interview on / at 9:09 AM, Caregiver B revealed, Resident #1 has not taken the medication yet because Resident #1 ate breakfast. Caregiver B stated, "I borrowed it because you were going to ask her. I swear that I haven't done it before, I was nervous."

Review of Resident #6's record revealed, there was a progress note completed on / / at 10:00 AM and it stated, "Today the doctor was called five times until answered because Caregiver B was very nervous and said that Resident #6's son said that prescription was in the pharmacy and she gave another from another resident but it was not the same that the doctor ordered because she gave the Bactrias 800-160 mg that belonged to Resident #1. Resident #6's physician ordered staff to monitor the resident for 12 hours and if any changes were noted, to send her immediately to the hospital. Resident #6 was told that the was 500 mg. The resident was explained what happened."

In an interview on / / at 12:06 PM, Caregiver C revealed, she wrote the medication order in resident #1's MORs.

In an interview on / / at 12:10 PM, Caregiver B revealed, the medications for Resident #1 arrived the day before on / / around 8:30 PM and Caregiver B did not sign the Medication Observation Record (MOR) because the medication arrived late at night. The caregiver further stated, Resident #1 did not take medication that morning on / / because Caregiver B gave Resident #1's medicine to Resident #6.

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SUMMARY STATEMENT OF DEFICIENCIES
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Review of Resident #1's medication cards on 11/16/16/at 12:11 PM showed, 14 tablets of - 800-1660 mg (DS). On 11/15/16, 14 tablets and instructions stated: take one tablet via oral every 12 hours for 7 days. There were 12 tablets left on / at 12:11 PM.
Resident #6 had a doctor's order for .500 mg to take half a tablet daily, if sugar is less than 100 do not take it. There was no doctor's order in Resident #6's record for the resident's self-testing for the sugar level. Resident #6's health assessment (AHCA form 1823) completed on / revealed, the resident needed assistance with self-administration of medication.
According to Mayo Clinic, is an oral medication for helping to control sugar level and one possible side effect can be low sugar levels. (low sugar) can be a dangerous condition. A very low sugar is a medical emergency and can lead to fainting, a or .
In an interview on / / at 1:30 PM, Caregiver C revealed, the facility did not keep a record of Resident #6's sugar level because Resident #6 checked the sugar level for herself.
In an interview on / / at 1:41 PM, the Owner revealed Resident #6 did not tell anyone about the sugar levels because the resident was not under any nursing services. The Owner further stated, Resident #6 was under a certain insurance and went to a clinic where doctors did not cooperate much.
In an interview on / at 1:50 PM, Caregiver B was asked, what was Resident #6's sugar level on / in the morning and Caregiver B stated, "I don't know. I don't get involved in that, she does it."

Class II

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observation, record review,and interview, the Assisted Living Facility failed to ensure Medication Observation Records (MORs) were immediately updated after each time the medication is offered or administered for 11 (#1, #2, #3, #4, #5, #6, #7, #8, #9, #11, #12) out of 12 sampled residents.

Findings included:

Observation on / / at 7:40 AM revealed that Caregiver C sat in the dinning table, opened the MORs book and started to initial Residents #2, #1 and #7's MORs.

Review of Resident #11's medicines in the MORs were not initialed for 8 AM doses on / / and 8 PM dose on / / . Review of Resident #11's MORs revealed that MORs did not include Resident #11's

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SUMMARY STATEMENT OF DEFICIENCIES
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Review of Resident #6's medicines in the MORs were not initialed for 8 AM doses on 11/16/16 and 8 PM dose on 11/15/16. Review of Resident #6's MORs revealed that MORs did not include Resident #6's and the health care provider's telephone number.

Review of Resident #12's medicines in the MORs were not initialed for 8 AM doses on . Review of Resident #12's MORs revealed that MORs did not include Resident #12's

Review of Resident #3's medicines in the MORs were not initialed for 8 AM doses on and 8 PM dose on . Review of Resident #3's MORs revealed that MORs did not include Resident #3's , the name of the Resident #3's health care provider and the health care provider's telephone number.

Review of Resident #8's medicines in the MORs were not initialed for 8 AM doses on and 8 PM dose on .

Review of Resident #4's medicines in the MORs were not initialed for 8 AM doses on and 8 PM dose on . Review of Resident #4's MORs revealed that MORs did not include Resident #4's

Review of Resident #9's medicines in the MORs were not initialed for 8 AM doses on 4 PM doses on and 8 PM dose on . Review of Resident #9's MORs revealed that MORs did not include Resident #9's

Review of Resident #5's medicines in the MORs were not initialed for 8 AM doses on and 8 PM dose on . Review of Resident #5's MORs revealed that MORs did not include Resident #5's

In an interview on at 7:40 AM the Caregiver B revealed that all residents took their morning medications.

In an interview on at 7:50 AM the Caregiver B stated "I gave medicines last night but I always sign them next day in the morning."

Review of Resident #2's MORs revealed that MORs did not include Resident #2's

Review of Resident #1's MORs revealed that MORs did not include Resident #1's

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Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the Assisted Living Facility failed to ensure that medications were secured at all times.

Findings included:

Observation on 11/16/16 at 7:34 AM revealed that Caregiver B went to the medication cabinet unlocked it, took medication card out of the medication cabinet and left the medication cabinet open. Caregiver B went to # . Caregiver B returned to medication cabinet in the kitchen on at 7:36 AM.

In an interview on at 2:20 PM the Caregiver B revealed that Caregiver B went to the resident's a quick moment.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on record review and interview, the Assisted Living Facility failed to follow doctor's orders and failed to obtain a specified doctor's order for an as -needed prescription for one (#6) out of 12 sampled residents.

Findings included:

Review of Resident #6's MORs on at 7:43 AM revealed that order for 800-160 mg take one tablet by mouth every twelve hours for seven days was not written on Resident #6's MOR. Resident #6's MORs included: 12.5 mg- take one tablet twice a day as needed- scheduled at 8 AM and 8 PM and 500 mg - take half a tablet daily if sugar is less than 100 do not take it- scheduled at 8 AM. 12.5 mg- take one tablet twice a day as needed- scheduled at 8 AM and 8 PM was initialed from through at 8 AM as given and from through at 8 PM. 500 mg - take half a tablet daily if sugar is less than 100 do not take it- scheduled at 8 AM was initialed from through at 8 AM as given but there was no proof that sugar level was higher than 100 mg/dl from through .

In an interview on at 1:30 PM the Caregiver C revealed that facility did not have sugar

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level record for Resident #6 because Resident #6 checked the sugar level for herself. was as needed for

In an interview on 11/17/16 at 1:41 PM the Owner revealed that Resident #6 did not tell anyone because Resident #6 was not under any nursing services. Resident #6 was under certain insurance and went to a clinic where doctor did not cooperate much.

In an interview on / at 1:50 PM the Caregiver B was asked what was Resident #6's sugar level on / / in the morning and Caregiver B stated "I don't know. I don't get involved in that, she does it."

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observation, record review and interview, the Assisted Living Facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern.

Findings included:

Observation on / / at 7:30 AM revealed that there were three caregivers in the facility at the time of the arrival, Caregivers B, D and E.

Review of Staff Scheduled posted in the bulletin board revealed that was labeled at the top " 2016." On Wednesday Caregiver B was scheduled from 6 AM to 6 PM, Caregiver D was scheduled from 6 PM to 6 AM and Caregiver E from 6 AM to 6 PM.

In an interview on / at 8:11 AM the Caregiver C stated "I change it every two months."

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation and record review, the Assisted Living Facility failed to note substitutions before or when the meal is served.

Findings included:

Observation on / / at 11:07 AM revealed that Caregiver B served lunch to Resident #11. Lunch

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tray had red beans soup over white rice and at the top sweet cookies, lettuce salad, beef with potatoes and carrots, and peaches, and for drinking water.

Menu posted in facility's refrigerator on / / at 11:08 AM revealed that menu was dated for week / - / / and the menu had for lunch on / / : steak or stewed beef, rice and beans, cassava, tomato/onion, salad dressing and peaches. Menu did not show any substitutions made for lunch.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview the facility failed to maintain the facility's liability insurance policy readily available at the licensee's physical address for review.

Findings included:

Review of facility's liability insurance policy posted in the bulletin board on / / at 7:47 AM revealed that facility's liability insurance policy expired on / / .

In an interview on / / at 8:08 AM the Caregiver C stated "I have it, I am going to send for it."

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview, the Assisted Living Facility failed to have documentation of the appointment of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney for one (#6) out of 12 sampled residents.

Findings included:

Review of Resident #6's record revealed that Resident #6's son signed the Medication Consent for Resident #6.

In an interview on / / at 12:22 PM the Caregiver C revealed that Resident #6 did not sign anything if the son doesn ' t sign it. Caregiver C revealed that there was no Power of Attorney/ Health Care Surrogate/ Guardianship in record.
On / / at 12:24 PM the Caregiver C called Resident #6 ' s son who confirmed to Caregiver C that

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Resident #6's son did not have Power of Attorney/ Health Care Surrogate/ Guardianship.
Class III

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Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c) FS

Based on observation, record review and interview, the Assisted Living Facility failed to have Affidavit of Compliance with Background Screening Requirements, in the employee's personnel file for three (Caregivers B, D and E) out of four employee's personnel files reviewed.

Findings included:

Observation on / / at 7:30 AM revealed that there were three caregivers in the facility at the time of the arrival, Caregivers B, D and E.

Review of Caregivers B, D and E's personnel files revealed that Affidavit of Compliance with Background Screening Requirements was not in caregivers' records at the time of the survey.

In an interview on / / at 10:09 AM Caregiver C revealed that Caregiver C did not remember receiving that forms the rest of Caregivers.
In an interview on / / at 10:14 AM the Owner revealed " I have it in blank there. "

Review of Caregivers B, D and E ' s records on / / at 10:22 AM revealed there were no attestations of compliance with background screening requirements in records at the time of the survey.
Unclassified.