STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965741	12/29/2016
NAME OF PROVIDER OR SUPPLIER **ABUELITAS HOME INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **15257 SW 61ST STREET** **MIAMI, FL 33193**	

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

0000 - Initial Comments

A complaint (CCR #2016014452) survey was conducted on 29th, 2016. Abuelitas Home Inc. with license number 10139 had the following deficiencies identified at the time of the survey:

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on observation, record review and interview, the Assisted Living Facility failed to ensure that one out of nine sampled residents meet the admission criteria.

Findings included:

Observation on at 7:08 AM revealed that Resident #2 was resting in bed with half-bed rail up.

Review of Resident #2's record revealed that date of admission was . Health Assessment (AHCA form 1823) completed on with medical history and diagnoses of Parkinson ' s , , , and ; physical or sensory limitations: unable to walk. or behavioral status: memory . Nursing/ treatment/ services requirements: hospice care. Resident needed total care for all activities of daily living (ambulation, bathing, dressing, eating, self-care, toileting, transferring). Resident was bedridden. Resident consent to the use of half- bed rail signed on . Review of Resident #2's hospice record revealed that she received hospice services since / . Review of plan of care on / revealed that resident was dependent for all activities of daily living and facility staff gave medicines. Nursing assessment on revealed that resident had , , poor balance. Physician note from and signed on revealed that resident was dependent on all activities.

An interview on at 8:38 AM the Administrator revealed that she has to look for the previous health assessment.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation and interview, the Assisted Living Facility failed to ensure that caregivers did not sleep in common areas.

Findings included:

Observation on / at 7:11 AM revealed that there was a personal mattress at the top of the sofa in

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the Florida room next to the dining .
An interview on at 7:11 AM the Administrator revealed that staff slept there.

Class III

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

Based on observation, interview and record review, the Assisted Living Facility failed to follow procedures outlined by the state while assisting one (Resident #3) out of nine sampled residents with self-administration of medication.

Finding included:

Observation on at 7:55 AM revealed that Caregiver A put all medicines together in a crusher and crushed medicines for Resident #3.

An interview on at 7:56 AM the Caregiver A stated regarding the medications "Yes, they are together."

Observation on at 7:58 AM revealed that Caregiver A took from crushed medicine powder and mixed it in a little cup with milk. Further observation at 7:59 AM revealed that Caregiver A put mixed of milk with medicines in a spoon and placed it inside Resident #3's mouth.

Review of Resident #3's Medication Observation Records (MORs) revealed that crushed medicines were: 50 mg tablet, 20 mg capsule, 600 mg tablet, 0.5 mg tablet, 40 mg tablet, 600 mg tablet. Reconciliation of Resident #3's medicines matched with Resident #3's MORs.

Review of Resident #3's record revealed that health assessment (AHCA form 1823) completed on / and showed that resident needed assistance with self-administration of medications.

Class III

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

Based on observation, and record review, the Assisted Living Facility's caregiver failed to maintain an accurate Medication Observation Record (MOR). The MOR was not immediately updated each time the medication was offered or administered to one of nine sampled residents (Resident #3) .

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Finding included:

Observation on 12/29/16 at 7:55 AM revealed that Caregiver A put all medicines together in a crusher and crushed medicines for Resident #3. Further observation at 7:59 AM revealed that Caregiver A put mixed of milk with medicines in a spoon and place it inside Resident #3's mouth.

Reconciliation of Resident #3's medicines matched with Resident #3's Medication Observation Records (MORs).Review of Resident #3's MORs revealed that crushed medicines were: 50 mg tablet, 20 mg capsule, 600 mg tablet, 0.5 mg tablet, 40 mg tablet, 600 mg tablet and they were not initialed after Resident #3 took her medicines.

Class III

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

Based on observation and interview, the Assisted Living Facility failed to keep medicines secured at all times.

Findings included:

Observation on at 7:30 AM revealed that there were medicines unlocked in facility's refrigerator which residents could have access to. The medicines were: - for Resident #2, 25 mg suppositories for Resident # 8 and liquid with which was not labeled.

Interviewed on at 9:17 AM, the Administrator revealed that medicines for Residents #7 and #8 were in a drawer under the kitchen stove.

Observation on at 9:20 AM revealed that medicines for Residents #7 and #8 were in draw under the kitchen stove.

Class III

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

Based on observation, record review and interview, the Assisted Living Facility failed to obtain a written medication order issued and signed by the resident's health care provider, or a faxed or electronic copy for change in directions of a medication for which the facility is providing assistance with self-administration prior to implementing the change for one out of nine sampled residents (Resident #3)

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Findings included:

Observation on 12/29/16 at 7:55 AM revealed that Caregiver A put all medicines together in a crusher and crushed medicines for Resident #3. Further observation at 7:58 AM revealed that Caregiver A took powder from crushed medicines and mixed it in a little cup with milk and Caregiver A at 7:59 AM put mixed of milk with medicines in a spoon and place it inside Resident #3's mouth.

Review of Resident #3's record revealed that there was no doctor's order on record for crushed medicines.

Interviewed on at 9:14 AM, the Administrator revealed that there was no doctor 's order for crushed medicines for Resident #3.

Class III

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

Based on observation, interview and record review, the Assisted Living Facility failed to maintain a written work schedule which reflects its correct staffing pattern for a given time period.

Findings Included:

Review of facility's record revealed that 2016 Staffing Pattern was posted in the bulletin board in the dining it showed that Caregiver B was scheduled to work on from 7 AM to 7 PM, Administrator was scheduled to work on from 7 PM to 7 AM, Caregiver A was scheduled to work on / from 7 AM to 7 PM and Caregiver C was not scheduled.

Interviewed via telephone on at 7:01 AM the Administrator stated "I am leaving my house and I'll be there soon, you will have to wait for me."

Observation on at 7:08 AM revealed that Caregiver C was that only staff present in that facility taking care of eight residents.

Observation on at 7:11 AM revealed that Administrator arrived to facility.

Observation on / at 7:18 AM revealed that Caregiver A arrived to facility.

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Observation on 12/29/16 at 7:23 AM revealed that Caregiver B arrived to facility.

An interview on at 7:28 AM the Administrator stated "Caregiver C covers night shift and she doesn't have paper work."

Class III

0083 - Training - First Aid and - 58A-5.0191(4) FAC

Based on observation, interview and record review, the Assisted Living Facility failed to have a staff member who has completed courses in First Aid and at all times.

Findings included:

Observation on at 7:08 AM revealed that Caregiver C was that only staff present in that facility taking care of eight residents.

An interview on at 7:28 AM the Administrator stated "Caregiver C covers night shift and she doesn't have paper work."

Review of Caregiver C's personnel file revealed that facility did not have any documentation for Caregiver C. Caregiver C did not have completed First Aid and .

Class III

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Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on observation and record review, the Assisted Living Facility failed to maintain documentation of an eligible Level II Background Screening in the employee's personnel file for one of four sampled staff (Caregiver A).

Findings included:

Observation on at 7:18 AM revealed that Caregiver A arrived at facility to provide care to residents.

Review of Caregiver A's personnel record revealed that her hire date was / and the documentation of the last eligible background screening result was dated / . Review of Caregiver A's background screening result in the Clearinghouse database revealed that her last screening was performed on .

Unclassified

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on observation and record review, the Assisted Living Facility failed to maintain an updated roster identifying the employment status of all employees within the Background Screening Clearinghouse Database.

Findings included:

A review of the Background Screening Clearinghouse Database showed that facility's employee roster was empty.

A review of the Administrator's personnel file revealed that the hire date was .

A review of Caregiver A's personnel file revealed that the hire date was / .

Observation on at 7:08 AM revealed that Caregiver C was that only staff present in that facility taking care of eight residents.

Observation on at 7:11 AM revealed that Administrator arrived to facility.

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Observation on at 7:18 AM revealed that Caregiver A arrived to facility.

Observation on at 7:23 AM revealed that Caregiver B arrived to facility.

Unclassified

Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on observation, interview and record review, the Assisted Living Facility failed to ensure that employees had an eligible Level II Background Screening result prior to providing care to residents.

Findings included:

Observation on / at 7:08 AM revealed that Caregiver C was the only staff present in that facility taking care of eight residents.

Interviewed on at 7:28 AM, the Administrator stated "Caregiver C covers night shift and she doesn't have paperwork."

A review of Caregiver C's personnel file revealed that it contained no documentation of any kind, and Caregiver C did not have a Level II Background Screening completed.

Unclassified.

Z824 - Right of Inspection; Inspection Reports - 408.811 FS; 59A-35.120 FAC

Based on observation and interview, the Assisted Living Facility failed to provide timely access to the facility for an unannounced compliance inspection.

Findings included:

Observation on at 6:53 AM revealed that facility had a gate outside the main door and it was locked. The gate did not allow access to ring the bell or to knock on the door.
On at 6:54 AM, the facility was called at the telephone number on file which was the Administrator's cell phone number. Administrator stated "They will open door now". Further call at 6:59 AM and at 7 AM to the Administrator were not answered. Administrator was called again at 7:01 AM and stated "I am leaving my house and I'll be there soon, you will have to wait for me."
Observation on at 7:07 AM revealed that the Caregiver C opened the facility's door and gate.
Unclassified

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Z828 - Administrative Fines; Violations - 408.813(3) FS

Based on observation and interviews, the Assisted Living Facility exceeded licensed capacity of 6 residents. The facility had a census of 8 residents.

Findings included:

Observation on at 7:08 AM revealed that Caregiver C was taking care of eight residents. There was one female resident sitting in a wheelchair in the living , one female resident in # , one female resident coming out of # while another was resting in bed with half-bed rail up. There were two male residents in # getting out beds. There were another two female residents in # , one of the in the the other one still in bed.

Interviewed on at 7:27 AM, the Administrator stated "I have eight residents."

Observation on at 9:20 AM revealed that medicines for Residents #7 and #8 were in draw under the kitchen stove. Medicines for Residents #1, #2, #3, #4, #5 and #6 were in the medication cabinet in the closet at the back of the kitchen.

Unclassified

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

Administrator
Abuelitas Home Inc
15257 Sw 61st Street
Miami, FL 33193

RE: CCR #2016014452

Dear Administrator:

This letter reports the findings of a complaint 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 , 2017.** 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) 593-300.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure 2016014452
XG90

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