| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11966897** | **05/30/2017** |
| NAME OF PROVIDER OR SUPPLIER<br>**MIRAMAR SENIOR LIVING** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**14934 SW 32 TERRACE**<br>**MIAMI, FL 33185** | |

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

**0000 - Initial Comments**

A Monitoring survey conducted on and concluded on . Miramar Senior Living , Inc had deficiencies identified at the time of the survey. Facility licensed #11034.

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

Based on record review and interview the facility failed to have accurate and completed health assessments for two of four sampled residents (Residents 1 and 3).

Findings included:

Record review of Resident #1's file revealed the health assessment (form 1823) dated on did not document hospice services and did not document weight information. Resident #1's progress notes dated on documented that the resident was under hospice care.

Interview on at 9:00 am Staff B stated, "Resident #1 is under hospice care."

Record review revealed Resident #3's health assessment dated on did not have diet orders.

Interview on at 1:20 pm Staff A stated, "I will let the doctor know that Residents 1 and 3's health assessment needed to be accurate."

Class III

**0053 - Medication - Administration - 58A-5.0185(4) FAC**

Based on observation, record review, and interview the facility failed to ensure that licensed personnel administer medications to three of four sampled residents (Residents 1-3).

Findings included:

Record review to the medication observation records (MORs) revealed Staff C initialed that staff gave medications to Residents 1-4 for the month of , (2017).

Interview on at 9:02 am Staff B revealed, "I give the medications to Residents 1-4 early this morning. Resident 1-3 cannot take the medication themselves. I put the medication in a plastic cup and I put it in their mouth. However, for Resident #1 I have to crush the medication and give to her with a spoon."

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

Further Interview on at 9:09 am Staff B reported, "I have my training to assist with self-administration of medications to the residents. I always have work with hospice residents and I always give them the medications."

Interview on 12:03 pm the hospice nurse stated, "We do not provide the regular medications for Residents #1 and #2."

Interview on at 2:00 pm Staff A and B confirmed Residents 1 and 2 needed administration of medication, and Staff B administered the medications for Residents 1 and 2.

Record review of Resident #1's file revealed the health assessment (form 1823) dated on documented the resident needed administration of medication.

Family interview on at 11:20 am revealed, "Staff B is providing the medication to my mother, there is a nurse from hospice is only for care."

Medication pass observations on at 1:05 pm showed Staff B placed a pill inside of a plastic cup with applesauce and crush them together.

Staff B walked to # where Resident #3 was sitting. Staff B took a spoon and poured the mix onto it. Then, Staff B took Resident #3's right hand, gave the resident the spoon. Staff B stated, "Resident #3 take your medication." Resident #3 did not follow the command therefore, Staff B took Resident #3's right hand assisted with administration of the medication.

Record review revealed Resident #3's health assessment dated on stated, "Needs administration of medication." Record review revealed Resident #3 did not have a doctor's order to crush medications.

Interview on at 1:10 pm Staff B stated, "I have to crush the medication because Resident #3 will not swallow it, and I have to grab the spoon because he cannot keep it in his hand."

Personnel records revealed Staff B and C were not licensed personnel.

Class III

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

Based on observation and interview the facility failed to keep medicines locked at all times and out of the

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

reach of residents.

Findings included:

Observation on at 8:59 am revealed medications ( 10 mg, 30 mg, Pentoxifylli 400 mg) were on top of the kitchen cabinet unsupervised.

Further observations on at 9:00 am revealed there were medications unlocked in facility's refrigerator. Two bottles of 0.004% inside of the refrigerator belonged to Resident #3.

Interview on at 9:00 am Staff B stated, "I am drinking those medications, and I keep them on the kitchen cabinet to remember that I have to drink them."

Class III

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Interview on at 1:20 pm Staff A stated, "I will let the doctor know that Residents 1 and 3's health assessment needed to be accurate."

Class III

**0053 - Medication - Administration - 58A-5.0185(4) FAC**

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Personnel records revealed Staff B and C were not licensed personnel.

Class III

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

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

Based on observation, record review, and interview the facility failed to have signed attestation forms on file for staff (A, B, C and D).

Findings included:

On at 9:10 am the facility's staffing pattern had Staff A, B, C, and D listed as working in the facility.

Record review revealed staff files did not have singed attestation forms on file at the time of the survey.

During an interview on at 2:11 pm, Staff A acknowledged staff did not have attestation forms on file.

Unclassified Deficiency