STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965734	**05/30/2017**
NAME OF PROVIDER OR SUPPLIER **MARY'S HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **14158 NW 88 PLACE** **HIALEAH, FL 33018**	

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

0000 - Initial Comments

An Abbreviated Biennial survey was conducted on and concluded on . Mary's Home, license #10073 had the following deficiencies at time of the survey:

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

Based on observation, interview, and record review, the facility failed to honor resident's rights for privacy and consideration by having 2 out of 7 (Residents #1 and #2) residents of different genders sleeping in the same .

Findings included:

On at 12:50 P.M. during the facility tour Staff B stated Residents #1 and #2 slept in # . At 12:47 Staff A stated that the residents are not related but their families did consent for them to share a . She stated I had a letter from them.

Attempted interviews with Resident #1 and #2 both residents were not interviewable.

During a family interview on at 1:30 P.M., Resident #1's wife stated that she did agree that her husband shared a female because was no other bed for him at the house. She stated I want this assisted living facility (ALF) for my convenience that it is walking distances from my house.

Class III

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

Based on observations and interview, the facility failed to follow proper procedure for assisting with self-administration of medication for 1 out of 7 (#1) sampled residents.

Findings included:

On at 01:11 P.M. Staff B observed taking a pill from a medication bottle on the kitchen countertop, two pills . Staff picked up pills, then placed one back to the bottle and the other one to the disposable. She walked to the Resident #1 and did not verbally prompting the resident with medication's name.

On at 1:15 P.M. Staff B stated only one pill did on the counter and I put it back to the medication bottle. She acknowledged that she did not prompt the resident or give the medication name

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to the resident. The administrator stated "but the counter is clean."

Class III

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

Based on record review and interview, the facility failed to ensure that the staff assisting residents with self-administration of medication updated the Medication Observation Record (MORs) immediately each time the medication was offered or administered for 1 of 7 sampled residents (Resident #2).

Findings included:

Review of Resident #2's MORs revealed that there was an order of medications: , 10 mg, , 2.5 mg, Megstrol mg, Montelukas 10 mg, , 40 mg on at 8:00 A.M. which we're not initialed by staff. The medication packs were emptied, furthermore, on at 8:00 P.M. medications and were not initialed by staff.

Interview on at 1:19 P.M. Staff B acknowledged the MORs was not initialed on , 8:00 P.M. and on at 8:00 A.M. for Resident #2. Staff stated, "I miss her page."

Class III

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

Based on observation, record review, and interview, the facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period to meet the scheduled and unscheduled needs of the residents (census of 7).

Findings included:

During tour of the facility on at 12:30 P.M. observed Staff B (caregiver) alone in the facility assisting 6 residents and 1 day care participant. Staff B stated the other staff went to the supermarket. Further observations on at 12:45 P.M. showed Staff A arrive to the facility.

Record review of the staffing schedule posted in the living the month of , 2017 showed the following: to ; Staff B from 7:00 A.M. to 4:00 P.M., Staff A from 7:00 A.M. to 8:00 P.M., Staff D from 8:00 P.M. to 7:00 A.M. and Staff C (off).

On at 3:50 P.M., the Administrator and consultant acknowledged that staffing scheduled was

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not followed.

Class III