STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966988	**06/05/2017**
NAME OF PROVIDER OR SUPPLIER **VARADERO RETIREMENT HOME CARE, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **15359 SW 23 LANE MIAMI, FL 33185**	

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

0000 - Initial Comments

An Abbreviated Biennial Survey conducted on . Varadero Retirement Home Care, Inc. had the following deficiencies found at the time of the survey (license #11101):

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

Based on observation, record review, and interview the facility failed to ensure that two of five sampled residents (Residents 1 and 6) met continued residency criteria. The facility also failed to have updated health assessments for two of five sampled residents (Residents 1 and 6) who had changes in their activities of daily living levels.

Findings included:

Observation on at 12:10 pm Staff D was feeding Resident #1's at the living . Staff B was feeding Resident #6 at the main dining .

Record review of Resident #1's Health Assessment stated, needs supervision while eating and needs assistance when transfer from one place to another.

Observation on at 1:22 pm showed Staff C and D transferring Resident #1 to her wheelchair; however, Resident #1 kept her knee bend while transferring. Resident #1 could not put her feet on the floor, and Staff C and D lift her to the wheelchair.

Record review of Resident #6's Health Assessment stated, "Needs supervision while eating."

Interview on at 1:30 pm Staff B stated, "Residents 1 and 6 usually take their lunch." Staff B also stated, "Resident #1 mostly assist with transfer, but today she is not as usual."

Class III

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

Based on observations, record review, and interview the facility failed to ensure that only licensed personnel administered medications to one of five (Resident #2) sampled residents.

Findings included:

Observation on at 12:00 pm revealed Staff C removed Resident #2's medication (, 0.5

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MG) card from the storage area. Staff C placed a pill inside of a plastic cup, explained medication to Resident #2, and put it in Resident #2's right hand. Then, Staff B approached Resident #2 with a glass of water and gave a Resident #2 the cup and also took the cup from Resident #2's hand with the pill still inside. Staff B saw that the medication inside of the cup, placed cup to the Resident #2's mouth and provide more water to the resident.

Record review revealed Resident #2's Health Assessment stated, needs assistance with self-administration of medication.

Interview on . . . . at 1:10 pm Staff B acknowledged that she provided medication directly from the cup to Resident #2's mouth.

Class III

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

Based on record review and interview the facility failed to maintain the employment status of all employees within the clearinghouse.

Findings included:

Review of the background clearinghouse revealed that the facility's employee roster did not have Staff B reflected as Administrator assistant. In addition, the facility's employee roster had Staff G listed as staff.

Interview on at 10:16 am Staff A stated, "Staff G is no longer working here since a year ago. In addition, Staff A stated, "Staff B is the Administrator Assistant of this facility, and she had her credentials."

Record review on revealed that Staff B was the Administrator Assistant of the facility.

Interview on at 1:30 pm Staff A and B stated, "I did not know that Staff B have to reflected as that Administrator Assistant." In addition, Staff B stated, "In our clearinghouse Staff G was not listed, and she reflected on AHCA's clearinghouse. We cannot understand that."

Unclassified