STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964689	**10/12/2017**
NAME OF PROVIDER OR SUPPLIER **AMANECER HOME ALF, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **11340 SW 47 TERRACE** **MIAMI, FL 33165**	

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

0000 - Initial Comments

A Standard Biennial Survey was conducted at on . Amanecer Home ALF with a Limited Mental Health component, license # 9386, had the following deficiencies found at the time of the survey:

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

Based on observation, record review, and interview, the facility failed to have qualified staff to meet the scheduled and unscheduled needs of six out of six sampled residents (Residents # 1 to # 6).

Findings included:

On at 8:40 A.M., Staff C was observed in the facility along caring for a census of six During an interview on at conducted with Staff E on at 06:23 AM, she stated that she was not working at the facility.

During an interview on at 8:40 A.M. observed Resident #6 very upset. He stated "I'm looking for my clinic phone number because I had my lab appointment and they didn't pick me up." Further observation Staff C was not able to assist the resident because she was cleaning, fixing beds, preparing breakfast and bathing other residents that needed assistance with ADL's.

At 9:25 A.M on , observed Resident #2 in bed with half bed rails up. Further observation revealed an unlocked medication cabinet and medications pre-poured inside the cabinet for Residents #2 and #4.

During an interview on at 9:27 A.M., Staff C stated "I'm giving breakfast and medication so that I can assist residents with bathing and dressing. The medications are initialed because I punched the medication pack in to the small disposable cup that you see there." At 10:12 P.M. Staff C stated "during day time I'm here alone with six residents."

Facility record review showed that the staffing scheduled was posted dated to revealed on Staff C from 7 A.M. to 7:00 P.M., Staff D (off), Staff E from 7:00 P.M. to 7:00 A.M. and Staff A from 5:00 P.M. to 10:00 P.M.

Resident's record review showed the following:

Resident #1's health assessment dated showed that the resident needed assistance with ADL's. Resident had precaution and the hospital medication discharge order and diagnoses dated

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, ( ), , and universal precaution.

Resident #2's health assessment dated showed diagnoses , , , insufficiency, . The resident had precautions and needed assistance with all activities of daily living (ADL's).

Resident # 4's health assessment dated revealed precaution and that the resident needed assistance with bathing and dressing, and supervision with ambulation, toileting and transferring.

Resident # 3's health assessment dated showed that the resident needed precautions and assistance with dressing and toileting and supervision with ambulation, bathing and toileting.

At 1:25 P.M. on , Resident #1 called Staff C to assist her with toileting.

At 1:30 P.M. on observed that Resident #1 needed the assistance of two staff for toileting. The administrator and owner transferred the resident from the sofa to the wheelchair.

Class III

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

Based on observation, record review and interview, the facility failed to have a physician's order for the use of half side bed rails for one out of six sampled residents. (Resident #2).

Findings included:

On at 9:25 A.M.,observed Resident #2 in bed with half bed rails up.

During an interview on at 9:43 A.M. Resident #2 stated "I cannot remove my bed rails, staff does it for me."

A review of Resident #2's record revealed that there was no documentation of a physician's order for the use of half bed rails.

Class III

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

Based on observation, and record review, the facilities failed to follow procedures outlined by the state

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during assistance with self-administration of medication for two out of six sampled residents. (Residents #2 and #4).

Findings included:

Observation on at 9:25 A.M., observed unlocked medication cabinet and medication were pre-poured inside the cabinet for Residents #2 and #4.

Review of Resident #2's Medication Observation Records (MOR) revealed that the medications listed were: 10 mg, 2 mg, 20 mg, HCTZ 12.5 mg, and 12 1,000 mg and D 2,000 unit at 8:00 A.M. Resident #4's MOR listed: 81 mg, 5 mg, 40 mg, 10 mg, sulf 325 mg, 2 mg and 100 mg at 7:00 A.M. The pills for both residents were inside the medication cabinet and were not offered to the residents, but were initialed by staff as having been taken.

On at 9:41 A.M., observed Staff C walk to the unlocked medication cabinet and take a disposable pre-poured medication cup for Resident #4. Staff walked back to the dining place cup with medication on top of the table. Staff C did not read medication names aloud to the resident. The MOR was initialed before staff offered medication to the resident. At 10:05 A.M. Staff C walked to the unlocked medication cabinet got a disposable pre-poured medication cup for Resident #2. Staff walked back to the dining place cup with medication on top dining table. Staff C did not read the medication name aloud to the resident. The MOR was initialed before staff offered the medication to the resident.

Class III

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

Based on record review and interview, the facility failed to ensure that the caregiver assisting residents with self-administration of medication updated the Medication Observation Record (MORs) immediately each time the medication was offered or administered for two out of six sampled residents (Resident #3).

Findings included:

Observation on at 9:25 A.M., observed unlocked medication cabinet and medication were pre-poured inside the cabinet for Residents #2 and #4.

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During an interview on at 9:27 A.M.,Staff C stated "I'm giving breakfast and medication so that I can assist residents with bathing and dressing. The medications are initialed because I punched the medication pack in to the small disposable cup that you see there."

Class III

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

Based on observation an interview, the facility failed to keep medication locked at all times for six out of six sampled residents. (Resident #1 to #6).

Findings included:

Observation on at 9:25 A.M., observed unlocked medication cabinet.

During an interview on at 9:27 A.M., Staff C acknowledged that medication cabinet was unlocked. She stated "I'm still assisting residents with their medications".

Class III

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(8) FAC

Based on record review and interview, the facility failed to ensure that three out of five sampled employees who provided care for residents under the mental health license component received a minimum of 6 hours of specialized limited mental health (LMH) training in working with individuals with mental health diagnoses within 6 months of being hired or 3 hours update training (Staff B, D and E).

Findings included:

A review of Staff B's personnel record revealed that he did not have 3 hours of continuing education on limited mental health. The last training was done on . Further review of staff records revealed that Staff D that was hired on and Staff E hired on . There was no documentation that Staff D or Staff E received 6 hours training on limited mental health within 6 months of hire.

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On . . . . at 1:40 P.M. the Administrator reviewed staff B, D and E's personnel records for the LMH training. She acknowledged the deficiencies.

Class III