STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964923	02/28/2018
NAME OF PROVIDER OR SUPPLIER **HAINAT, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2435 SW 82 AVENUE** **MIAMI, FL 33155**	

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

0000 - Initial Comments

A Standard Biennial Survey was conducted on , 2018. Hainat, Inc. with limited mental health component and license #9679 had the following deficiencies identified at the time of the survey:

0031 - Resident Care - Third Party Services - 58A-5.0182(7) FAC

Based on record review and interview, the Assisted Living Facility failed to provide records of the daily , services administered by a home health agency to one of six sampled residents (Resident #1) .

Findings included:

Review of Resident #1's record revealed that the admission date was on . There was a doctor's order for Home Health evaluation and treatment for administration once a day, Lantus 35 units , signed on . There was a doctor's order on to discontinue 100 mg and start daily and Iron pills daily. There was a doctor's order signed on for Lantus increased to 35 units at bedtime. There was no evidence that home health agency's license staff administered to Resident #1.

In an interview on at 11:10 AM with Licensed Practical Nurse from the home health agency revealed that the agency used to leave documentation in the house but the agency did not have those forms.

Class III

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

Based on record review and interview, the Assisted Living Facility failed to ensure that Medication Observation Records (MORs) were updated immediately each time medicines were offered or administered for five out of six sampled residents (#1, #2, #3, #4, and #6). The facility also failed to ensure that MORs included Resident's for two out of six sampled residents (Residents #5 and #6).

Findings included:

In an interview on at 8:13 AM Staff B stated, "I just gave medicines."

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Review of Residents #1, #2, #3, #4 and #6's MORs revealed that Staff did not initial medicines for 7 AM on .

Review of Residents #5 and #6's MORs revealed that they did not identified the .

Class III

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

Based on record review and interview, the Assisted Living Facility failed to obtain clarification orders for a medication ordered as needed. The facility also failed to notify the doctor of changes needed with the orders for two out six sampled residents (#3 and #6).

Finding included:

Review of Resident #3's Medication Observation Record (MOR) revealed that there was an order for - Aceta 37.55 take one tablet by mouth twice a day as needed for pain. The medicine was scheduled at 7 AM and 5 PM. The medicine was initialed as given every day from to at 7 AM and from to at 7 PM. Staff signed at 7 AM and 7 PM from thru .

In an interview on at 12:08 PM, the Administrator stated, "If we gave it like that, she did not complaint of pain."

Review of Resident #6's MORs revealed that there was an order for , Art 650 mg- take one tablet by mouth twice a day as needed for pain.

In an interview on at 12:15 PM, the Administrator stated, "If Resident is not medicated, Resident started to scream. We kept giving it twice a day for pain under control". At 1:09 PM, the Administrator revealed that s/he was a CNA (Certified Nursing Assistant) and that Staff B was not a licensed staff.

Class III

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

Based on observation, record review and interview, the Assisted Living Facility failed to maintain the

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minimum staffing hours per week for 6 residents of 212 hours. Facility's staff hours hours per week was 168 hours.

Finding included:

Observation on at 8:20 AM revealed that Staff B was on duty. Residents #1, #2, #3, #4, #5 and #6 were in the facility.

Review of Staff Schedule for 2018 showed that on week - Administrator worked from 24 hours on , and from 7 PM to 7 AM on , , , , and . Administrator worked 84 hours in the week. Staff B worked from 7 AM to 7 PM on , , , , and but on worked 24 hours. Staff B worked 84 hours on the week.

In an interview on at 2:48 PM, the Administrator revealed that s/he did not find good staff.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on record review and interview, the Assisted Living Facility failed to ensure that one of two sampled, unlicensed Staff who provided assistance with self-administered medications had successfully completed the initial 4 hour training on providing assistance with self-administered medications and safe medication practices in an assisted living facility (Administrator).

Findings included:

Review of Administrator's personnel file revealed that the hire date was on . There was a training certificate for assisting with self-administration of medication for 6 hours on . No credentials were listed for the trainer (No name, no license number) . It just had RN initials next to signature.

Review of Staff Schedule for 2018 showed that in the week of - , the Administrator worked 24 hours on , and from 7 PM to 7 AM on , , , , and .

In an interview on at 10 AM, the Administrator revealed that s/he assisted residents with

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self-administration of medications. The Administrator further stated that the who gave assistance with self-administration of medication training no longer worked with the facility. The Administrator did not have a contact number for the trainer. The Administrator knew that trainer was a Register Nurse but did not have proof of the credentials.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation, record review and interview, the Assisted Living Facility failed to have menus dated and planned at least one week in advanced. The facility also failed to note substitutions before or when meals were served.

Findings included:

1. Review of facility's the bulletin board revealed that a menu dated for week to was posted.

In an interview on at 9 AM Staff B stated, "Administrator should have changed it yesterday because I saw the Administrator working on the bulletin board."

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the Assisted Living Facility did not have required furniture in residents' .

Findings included:

Observation on at 8:15 AM revealed that # did not have closet or wardrobe space for hanging clothes, and did not have a waste basket. # did not have waste basket. # did not have a night lamp or floor lamp.

Observation on at 8:22 AM revealed that Resident #1's not have a waste basket.

In an interview on at 2:50 PM Administrator revealed that facility supplied the furniture for residents' . Resident #1's family just brought the chest.

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Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on observation and record review, the Assisted Living Facility failed to obtain the accurate Resident consent to the use of bed rails for one out of six sampled residents (Resident #5). The resident had a signed consent for use of half-bed rails , but used full bed rails. The facility failed to have an accurate health assessment for one out of six sampled residents (Resident #5) .

Findings included:

1. Observation on at 8:22 AM revealed that Resident #5 rested in bed with a full bed rail up.

Review of Resident #5's record revealed that there was a doctor's order received via telephone via for a full bed rail signed on by a hospice nurse. The Resident consented to the use of half-bed rail signed on by the Resident's son.

2. On at 1:34 PM observed Staff B feed Resident #5 with puree food. A review of Resident #5's health assessment completed on showed that the Resident needed total assistance for all activities of daily living. It indicated that Resident needed assistance for self-administration of medications.

In an interview on at 12:02 PM, the hospice nurse revealed that the Resident received medication administration from hospice nurses.

Class III