STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968365	**04/30/2018**
NAME OF PROVIDER OR SUPPLIER **MAYI'S ALF INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **14053 BRIARDALE LN CARROLLWOOD, FL 33618**	

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

0000 - Initial Comments

Assisted Living Facility

An unannounced complaint survey (CCR#2018003559) was conducted on . . . . . at Mayi's ALF Inc. (License #12274), an assisted living facility located in Tampa, Florida. There were deficiencies identified during the survey.

0051 - Medication - Pill Organizers - 58A-5.0185(2) FAC

Based on observation and interview, the facility failed to ensure that only a licensed nurse removed medications from the primary packaging and placed medicationinto small plastic containers (pill organizers) for one (#3) of two daycare participants who received supervision or assistance with self-administration of medication.

Findings included:

On at 09:50 a.m., a clear container wasobserved containing red clear pills. The Administrator grabbed the cup and handed the cup to Staff A. The two red pills on the kitchen counter.

On . . . . . at 10:14 a.m., the Administrator stated that medication was prepared (removed from primary packaging) for Day Care Participant #3 and after the removal of the medication, the participant refused the dosage.

Review of the medication observation record revealed no documentation of Participant #3's dosage refusal.

Class III

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

Based on observation, interview, and record review, the facility failed to provide assistance with self-administered medications in accordance with procedures described in Section 429.256, F.S. Specifically, unlicensed staff (Administrator) administered oral medication for one resident (#4), and failed to remove medication from primary packaging in the presence of resident for two (#4 and #5) of two residents selected observation.

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Findings included:

During an observation of assistance with self-administration of medication with the Administrator, on at 04:41 p.m., the Administrator removed medication from its original packaging near the facility kitchen without Resident #3 present, and placed the medication dosage in apple sauce. The Administrator was then observed spoon feeding Resident #3 the medication dosage, with no assistance or participation from Resident #3.

During continued assistance with self-administration of medication observation, on at 05:05 p.m., the Administrator removed the medication dosage for Resident #4 from the original packaging, near the kitchen, without Resident #4 present, walked to the outdoor lanai and provided Resident #4 with the medication dosage.

Class III

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

Based on record review and interview, the facility failed to maintain an accurate and up-to-date Medication Observation Record (MOR) that reflected an accurate record of medications and listed each time medications were provided to residents for three (#4, #5 and #7), of four residents, and two (#2 and #3) adult day care participants selected for medication review.

Findings Included:

On at09:40a.m., the Administrator was observed adding her initials to the Medication Observation Records (MOR) from , , 2018 to current date. When questioned, Administrator confirmed that she was completing/initialing the MOR. She stated that she gave the medications in the morning before going to the school on the dates in question. The Administrator confirmed that she gave the medications at 07:00 a.m. on .

Brief review of the MOR for adult day care participants (#1 and #2), and assisted living residents (Resident #4, Resident #5, and Resident #7) revealed that medications were not documented as given since , totaling ten days.

During interview with the Administrator, on at 10:14 a.m., she confirmed that she has not completed the MOR since the , and stated "sorry-sorry, it's just that I am the only one that does the medications. I am busy with school and I forgot."

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On at 5:05 PM, the administrator was observed providing a medication dosage for Resident #4 that was not listed on the MOR. The Administrator confirmed that the medication was ordered on , and stated that she had not updated the MOR to reflect the change in medication orders.

Class III

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

Based on observation, record review and interview, the facility failed to ensure that abandoned medications were destroyed or returned to the pharmacy for one of one residents (Resident #1).

Findings included:

Review and observation of medication on at 10:00 a.m. revealed that facility had medication bubble packaging with dosages stored in the medication cabinet.

During interview with the Administrator, on at10:05 a.m., she initially stated that the tablets observed were . Review of the medication packages revealed that the dosages were stool softeners, fill date . The Administrator confirmed the dosages were for Resident #1 who , on . The Administrator stated that she forgot to send them back to the pharmacy.

Class III

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

Based on observation and interview, the facility failed to maintain a written work schedule that accurately reflected the direct care staffing pattern.

Findings included:

Facility tour conducted on , approximately at 09:00 a.m., revealed no evidence of a posted staffing schedule. A request for direct care staffing schedule received no response by the Administrator.

During a follow-up request for a direct care staffing schedule, on at 01:26 p.m., the Administrator stated that the facility does not maintain a direct care staffing schedule, and stated the facility has not maintained a staff schedule for a year.

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Class III

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

Based on observation, interview and record review, the facility failed to ensure that one of one unlicensed staff (Administrator) observed administering and providing assistance with self-administered medications for two (#4 and #5) of four residents, completed the required training, provided by a registered nurse or licensed pharmacist.

Findings included:

On [redacted] at 04:41 p.m., the Administrator was observed administering medication for Resident #4 and providing assistance with medication self-administration for Resident #5.

Record review, on [redacted], revealed no evidence that the Administrator completed the assistance with self-administration update course. The last assistance with self-administration training completed by the Administrator was dated [redacted].

Review of Medication Observation Records for Resident #4 and #5 revealed that only the Administrator documented assisting with medications for the residents.

On [redacted] at 06:00 p.m., the Administrator stated that she believed that the medication training update was supposed to be every two years. The Administrator confirmed that she was the only staff that assisted with medication for all residents and adult day care participants.

Class III