STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963880	05/01/2018
NAME OF PROVIDER OR SUPPLIER **SAN CAYETANO HOME, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **3525 SW 104 COURT** **MIAMI, FL 33165**	

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

0000 - Initial Comments

A complaint (CCR #2018001993) survey was conducted on , , 2018 and concluded on , , 2018. San Cayetano Home, Inc. (license #8859) had the following deficiencies identified at the time of the survey:

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

Based on observation and interview, the Assisted Living Facility failed to follow the correct procedure as outlined in section 429.456 of Florida Statutes when assisting with self-administration of medications for seven (#1, #2, #4, #5, #6, #7 (2), and #8) out of eight sampled residents.

Findings included:

1. On at 6:16 AM observed that there were eight small plastic cups with residents' names printed in the front. They had medications inside of them that were prepared in advanced. The medications were labeled for Residents #1, #2, #4, #5, #6, #7 (2), and #8. Staff did not take medications, in their previously dispensed, properly labeled containers, from where their were stored, and brought them to the residents. Staff, in the presence of the resident, did not read the label, open the container, remove a prescribed amount of medication from the container for Residents #1, #2, #4, #5, #6, #7 (2), and #8.

On at 6:16 AM Staff C stated, "Staff D prepared medicines in the morning when the staff woke up."

On at 6:34 AM Staff D revealed that she prepared medications and signed the medication observation records (MORs) in advance of giving the residents' medications.

2. On at 6:43 AM observed Resident #1 rested in bed in # with full bed rail up. Staff C arrived to breakfast tray on hand. Cup with medications were on the trays. Staff did not bring the medications' cards. Staff did not read the medications' names to resident.

On at 6:43 AM Staff C staff stated, "there are days that Resident helps but it depends. Resident #1 holds the cup." While Staff put the cup with medications in the resident's hand. Staff put hand over hand and put cup with medication in resident's mouth. Resident took out medications from the mouth. Staff did not use gloves. Staff took medications that the resident took out from mouth previously and Staff reinserted with the hand (staff) in the resident's mouth in four different occasions.

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Class III

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

Based on observation, record review and interview, the Assisted Living Facility failed to ensure that Medication Observation Records (MORs) must be signed at the time medication is given for six (Residents #2, #4, #5, #6, #7, and #8) out of eight sampled residents. Staff signed for medications that were not assisting residents with for one (#8) out eight sampled residents. Staff did not immediately update the MOR each time the medication was offered or administered for one (#2) out of eight sampled residents.

Findings included:

1. Review of Resident #2's MOR revealed there was an order for [redacted], ER 650 mg capsule to take one capsule by mouth twice a day. It was schedule at 8 AM and 8 PM. Staff did not sign the MOR on [redacted] and [redacted].

On [redacted] at 1:03 PM Staff D stated, "I forgot to sign".

Review of Resident #6's MOR revealed that Staff did not sign the MOR for the doses of 8 AM, 2 PM and 8 PM of any of the medications [redacted] and [redacted]. Staff on [redacted] did not sign the MOR for the doses of 2 PM and 8 PM of any of the medications.

Review of Resident #4's MOR revealed there was an order for [redacted], Furamate 100 mg tablet to take one tablet by mouth once daily at night at bedtime. It was schedule at 8 PM. Staff did not sign the MOR on [redacted] and [redacted].

On [redacted] at 1:08 PM Staff C stated, "Probably Staff D forgot to sign".

Review of Resident #5's MOR revealed there was an order for [redacted] 500 mg tablet to take one tablet by mouth once daily at bedtime. It was schedule at 8 PM. Staff did not sign the MOR on [redacted] and [redacted].

Review of Resident #7's MOR revealed there was an order for [redacted], Furamate 25 mg tablet to take one tablet by mouth twice a day at 8 AM and 6 PM. It was schedule at 8 PM. Staff did not sign the MOR on [redacted] and [redacted] for 6 PM dose. There was an order for [redacted] D 5,000 unit tablet to

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take one tablet by mouth three times a week. Staff signed the MOR every day.

2. Review of Resident #8's MOR revealed that order for Lantus 100 units/ML vial to inject 35 units one time a day. Staff signed it from . . . . . to . . . . . at 8 AM.

On . . . . . at 2:15 PM Staff C revealed that there was a nurse who gave . . . to Resident #8. They did not know the name or phone number for the nurse neither for the home health agency. Staff did not give the . . . to the Resident #8.

Class III

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

Based on observation and interview, the Assisted Living Facility failed to keep medications locked at all times.

Findings included:

On . . . . . at 6:15 AM observed that the medication cabinet was opened. The medication cabinet's locked was opened. Staff did not open it. At 6:16 AM observed that there were eight small plastic cups with residents' names printed in the front. They had medications inside that were prepared in advanced. Medications were labeled for Residents #1, #2, #4, #5, #6, #7 (2), and #8. There were boxes with medicines for eight out of eight sampled residents.

On . . . . . at 6:15 AM Staff C revealed that the staff just opened the medication cabinet.

Class III

0057 - Medication - Over The Counter (OTC) Products - 58A-5.0185(8) FAC

Based on record review, observation and interview, the Assisted Living Facility failed to ensure that stock supply of Over the Counter (OTC) products were not used for multiple residents and were labeled as required with the resident's name for two (#4 and #5) out of eight sampled residents.

Findings included:

Review of Resident #5's Medication Observation Record (MOR) revealed that there was an order for MAPAP 500 mg tablet to give one tablet by oral route two times per day as needed for . Staff

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signed it from . . . to . two times a day. Staff did not document at what time the medication was given.

On . . . . . at 1 PM observed that there was a bottle of MAPAP 500 mg tablet in the medication cabinet.

On at 1:13 PM Staff D revealed that uses the same bottle of MAPAP 500 mg tablet for Residents #5 and #4. In further interview at 1:30 PM, the staff revealed that was not a licensed staff.

On . . . . . at 1:13 PM Staff C revealed that Resident #4 did not have MAPAP 500 mg tablet in the MOR. MAPAP was OTC and it was not label. Resident #5 took the MAPAP for the pain in the back. In further interview at 1:27 PM, the staff revealed that was not a licensed staff.

Class III

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on record review and interview, the Assisted Living Facility (ALF) failed to appoint a Manager for each facility.

Findings included:

Review of the health finder website revealed the Administrator supervised two Assisted Living Facilities (ALFs).

Review of facility's record revealed that Administrator did not appoint a manager for present facility.

Review of background screening database showed Manager supervised the same two ALFs that the Administrator supervised.

On . . . . . at 10:10 AM Staff D confirmed that Administrator had two ALFs and the manager supervised the same two ALFs. Staff D stated, "I thought she could do it."

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

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

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updated admission and discharge log.

Findings included:

On at 6:08 AM observed Resident #7 rested in bed in # . On at 6:10 AM observed that Resident #8 was in the first the hallway between #1, #2 and #3.

Review of admission and discharge for residents did not include Residents # 7 and #8.

On at 7:17 AM Staff C revealed that Resident #8 was new in the facility; Resident #8 just moved two days ago. The facility did not have anything for any documentation for Resident #8. Resident #7 was in the admission and discharge as a day care participant.

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Z828 - Administrative Fines; Violations - 408.813(3) FS

Based on observation, record review, and interviews, the Assisted Living Facility (ALF) exceeded licensed capacity of 6, the facility had a census of 8 residents and day care participants.

Findings included:

On at 6:07 AM Resident #2 rested in bed with full bed rail up in # . Resident #3 rested in bed with half-bed rail and at 2 liters via nasal cannula from concentrator in # .

On at 6:08 AM Resident #7 rested in bed in #.

On at 6:08 AM Staff D stated, "Resident #7 stayed here last night."

On at 6:09 AM, there were two residents who rested in their beds in # . Resident #1 rested in bed with full bed rail up. Resident #6 rested in the other bed. At 6:10 AM, Resident #5 rested in bed in # .

On at 6:10 AM observed that Resident #8 was in the first the hallway between #1, #2 and #3.

On at 6:10 AM Resident #4 rested in bed in # .

On at 6:10 AM Staff C revealed that Resident #8 slept in # . At 6:13 AM the staff stated, " Why would I give you explanation; it does not make any sense that I try to explain."

On at 6:15 AM observed the medication cabinet was opened. The medication cabinet's locked was opened. Staff did not open it. At 6:16 AM observed that there were eight small plastic cups with residents' names printed in the front. They had medications inside that were prepared in advanced. Medicines were labeled for Residents #1, #2, #4, #5, #6, #7 (2), and #8. There were boxes with medicines for eight out of eight sampled residents.

Review of MORs for eight residents completed on at 6:20 AM. It revealed that morning doses for seven residents (except Resident #3) were initialed as given on .

On at 10:26 AM the home health nurse revealed that they provided services for management to Resident #8 at the facility's address for the last year and a half. Nurse went to facility on

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daily basic to facility to provide . . administration between 7 AM and 8:30 AM.

On at 11:14 AM home health's Administrator revealed Resident #8 received services with them since . . . . . , 2015. The Administrator checked the plan of care on the system during the interview at least the last 60 days, Resident #8 received services at facility's address.

Review of Resident #8 home health's record revealed start of plan of care completed on at the ALF's address. It showed that emergency contact was facility's administrator. The living arrangement portion showed that patient lived in an assisted living facility. Resident agreement with the facility signed on . . . . . .

Unclassified