STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966915	**05/21/2018**
NAME OF PROVIDER OR SUPPLIER **DIAZ HOME CARE ALF, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **13481 SW 268 TERRACE** **HOMESTEAD, FL 33032**	

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

0000 - Initial Comments

A standard biennial survey was conducted on , 2018. Diaz Home Care Alf, Inc., with a limited mental health component and license number 11119, 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 Florida Statutes, when assisting with self-administration of medications to one out of six sampled residents (#1) . Staff did not read aloud the medications' names.

Findings included:

Observed on at 7:27 AM that Staff B, washed hands, unlocked and took scheduled medicines out, checked medication cards with medication observation records (MORs). The staff took medications out of medication cards and handed a small disposable cup with medications inside to the resident. Staff B did not read the medications' names to Resident #1.

Reconciliation of Resident #1's medications revealed that morning medications were:
- 20 mg tablet- take one tablet daily
- 20 mg tablet- take one tablet daily
- 0.5 mg tablet- take one tablet by mouth twice a day
- 50 mg tablet- take one tablet in the morning.
- 5 mg tablet- take one tablet twice a day.
- Sod DR 250 mg tablet- take one tablet in the morning.
- 50 mcg tablet- take one tablet in the morning.
- CL ER 10 MEQ tablet- take one tablet daily.

On at 2:27 PM, Staff B acknowledged not having read aloud the medication names to Resident #1

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

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SUMMARY STATEMENT OF DEFICIENCIES
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Observation Records (MORs) included Residents' for two out of six sampled residents (Residents #1 and #2) .

Findings included:

Review of Resident #1's MORs revealed that it did not identify the . Resident #2's MOR also did not identify the .

Review of Resident #2's record revealed that health assessment (AHCA form 1823) completed on showed that the Resident had an to , Sulpha and phenothiazine.

In an interview on at 2:30 PM, the Administrator stated that facility staff would ensure that the pharmacy corrected the section in the MORs for all residents.

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 a written work schedule that reflected its 24-hour staffing pattern.

Findings included:

On at 7:20 AM Staff B was in the facility alone with 4 residents.

On at 7:20 AM, Staff B revealed that there were 5 residents, one of them was out to the program, the rest were still in the facility.

On at 8:04 AM Staff C arrived.

Review of Staffing schedule for week from to showed that Staff C worked from to from 7 AM to 7 PM. Staff B worked from to from 7 AM to 7 PM.

On at 2:29 PM Administrator stated that Staff C was late.

Class III

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SUMMARY STATEMENT OF DEFICIENCIES
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0090 - Training - - 58A-5.0191(11) FAC

Based on record and interview, the Assisted Living Facility failed to to ensure that one out of five sampled staff received at least one hour of training on the facility's policy and procedures regarding ( ) within 30 days after employment (Staff C).

Findings included:

Review of Staff C's personnel record revealed that hire date was . There was no documentation of training in record for Staff C.

On at 12:34 PM, the Administrator revealed that she was not able to find the training, probably because she did not make the copies.

Class III

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

Based observation and interview, the Assisted Living Facility failed to have required furniture in residents'.

Findings included:

On at 7:57 AM, Staff B revealed that Residents #3 and #5 slept in #.

On at 7:57 AM observed that # did not have a bedside lamp or stand lamp and a waste basket.

On at 7:59 AM, Staff B revealed that Residents #1 and #2 slept in #.

On at 7:59 AM observed that # did not have a dresser, chest or other furniture designed for storage of clothing or personal effects, a bedside lamp or stand lamp and a waste basket.

Class III

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

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SUMMARY STATEMENT OF DEFICIENCIES
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Based on observation, record review and interview, the Assisted Living Facility failed to have an accurate health assessment for one out of six sampled residents (Resident #1) .

Findings included:

On . . . . at 8:35 AM, two nurses from hospice arrived to administer medicines to Resident #1.

Review of Resident #1's Medication Observation Records (MORs) revealed that nurses from hospice initialed the MORs.

Review of Resident #1's health assessment completed on showed that the resident needed assistance with self-administration of medication, not medication administration.

Class III