STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911004	07/05/2018
NAME OF PROVIDER OR SUPPLIER **MILLER HEIGHTS HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **4930 SW 87 AVENUE** **MIAMI, FL 33165**	

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

0000 - Initial Comments

A Complaint Survey (CCR# 2018009093) was conducted on . Miller Heights Home, License #7463, had the following deficiencies identified at the time of the survey:

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

Based on observation, interview, and record review, the facility failed to provide adequate supervision to the residents and failed to maintain a written record of any incidents that resulted in medical attention for 1 out of 7 sampled residents (Residents #2).

Findings included:

On at 7:13 AM observed Resident #2 was sitting on the floor. The resident stated she was not feeling well and that she had not but that she did not feel well and she slipped off the bed.

A review of Resident #2's record showed the resident was admitted , health assessment dated , showed medical history and diagnoses: Type 2 with , angropathy, , high type purpura vertiginous . Physical or sensory limitations: Blurred vision, decreased hearing, with exertion, incontinence, stiffness. or behavioral status: Moderate . precautions. The resident needs assistance with ambulation, bathing, self-care ( ), transferring, and needs supervision with dressing, eating, and toileting. Special Diet Instructions: Calorie controlled. The resident needs assistance with self-administration of medications.

A review of Resident #2's last progress note on file was dated and documented: Resident #1 apparently shows to be oriented but sometimes she is not. She eats very well. She is recently adjusted with her sister and her son and it is due to her own disorientation.

A review of Resident #2's hospital discharge note showed the resident was admitted on for major , recurrent episode, severe.

On at 10:25 AM Spoke to Resident #2's son, he stated "My mom has been there for 2 years. We see her often, we are not sure of what is wrong with her, and the doctor tells us that she has but not sure, if she has . In reference to falling, she has a couple of times. Sometimes she has in the hospital. The last time she was a week ago. She is much disoriented;

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	AL11911004	**07/05/2018**
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they called me during day light, I am not sure at what time, I think it was afternoon."

Class III

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

Based on observation and interview the facility failed to treat the resident consideration by not allowing the resident access to refrigerator.

Findings included:

On at 7:11 AM observed refrigerator in the facility with a lock, unable to open the door. The facility also did not have snacks available to the residents.

On at 7:38 AM Administrator stated "We put a lock on the refrigerator because some of the family members bring snacks and then residents in the middle of the night eat the snacks of other residents and they argue about it."

Class III

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

Based on interview and record review the facility failed to follow the correct procedure as outlined in section 429.456 of Florida Statutes, when assisting 1 out of 1 sampled resident with self-administration of medications (Resident #3).

Findings included:

On at 8:01 AM requested to see medication pass observation. Staff B, stated she had given medication at 6:30 AM.

A review of the medication observation record MOR for Resident #6 revealed the resident had prescribed 3.125 MG 1 tab 2 x a day at 8:00 AM.

Class III

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

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	AL11911004	**07/05/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Based on record review, observation, and interview the facility failed to maintain medication observation records (MORs) for 2 out of 7 sampled residents (Resident #4 and #5).

Findings included:

A review of the facility's medication observation records (MORs) revealed the facility did not have records for Resident #4 and Resident #5.

On at 8:00 AM observed Resident #5's packets and Resident #4's medication bottles in medication cabinet. Resident #5 had prescribed 0.5 MG 1 tab daily, 20 MG 1 tab daily, and 5 MG 1 tab daily. Resident #4 had prescribed 3.125 MG 1 3 x a day, 15 MG 1 x 3 x a day, 25 MG 1 tab daily, 5 MG 1 tab 3 x a day, 40 MG 3 x a day, 20 MG 1 x a day, 2.5 MG 2 x a day, 4 MG every 8 hours, 30 MG 1 cap a day, 25 MG 3 x a day, 81 MG daily.

On at 8:34 AM the Administrator stated "These two residents do not have the medication observation record sheets because I forgot to request new ones from the pharmacy."

Class III

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

Based on observation and interview, the facility failed to maintain centrally stored medications in a locked cabinet and out of the reach of all residents.

Findings included:

On , 2018 at 7:30 am, observed in the back open area used for office/dining area, a cabinet door with an unlocked lock with medications for Resident 2.

On , 2018 at 12:45 pm during the exit conference, the Administrator acknowledged that the door was left open and stated, "This cabinet is used by the resident's health home care person".

Class III

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

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911004	**07/05/2018**
NAME OF PROVIDER OR SUPPLIER **MILLER HEIGHTS HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **4930 SW 87 AVENUE** **MIAMI, FL 33165**	

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Based observation and interview the facility failed to have a 3-day supply of nonperishable food available on hand at all times.

Findings included:

On at 7:35 AM observed there was insufficient amount of the required 3-day supply of nonperishable food for a census of 7 residents.

On at 7:40 AM the Administrator stated "Today is the day I have to go to buy the food for the facility, we have been using the emergency food for every day food because the food expires. I will increase the emergency food today."

Class III

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

Based on observation and interview, the facility failed to maintain a safe living environment free of hazards for six of seven residents, (Residents #1, #2, #3, #4, #5, #6, and #7).

Findings Included:

On , 2018 at 7:10 am, observed the facility did not have toilet paper in the during the tour. The ceiling was stained on the main . Observed outside at the back area had construction debris, materials, and discarded furniture.

On , 2018 at 12:45 pm during the exit conference, the Administrator acknowledged the findings, asked the staff to replace the toilet paper and stated, "The dining table was replaced this week and we need to through it away, some of the construction things were used during the last storm."

Class III

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

Based on record review and interview, the facility failed to maintain on file all resident forms signed by the resident or power of attorney for one of six residents, (Resident #6).

Findings Included:

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Record review for Resident 6 showed resident's admission date of . Record review showed all facility forms dated and signed by Administrator on . Records showed there was no signature from either resident or a power of attorney.

On , 2018 at 12:30 pm during the exit conference, the Administrator acknowledged that all forms were not signed by the resident or the power of attorney and stated, "The daughter is the power of attorney, I do not know how I missed it, it will be done as soon as possible".

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on observations, record review, and interview, the facility failed to complete a one day and 15 day full report to the Agency after 1 out of 7 sampled residents who had a precautions .

Findings included:

On at 7:13 AM observed Resident #2 was sitting on the floor. The resident stated she was not feeling well and that she had not but that she did not feel well and she slipped off the bed .

On at 10:25 AM Spoke to Resident #2's son, he stated "My mom has been there for 2 years. We see her often, we are not sure of what is wrong with her, and the doctor tells us that she has but not sure, if she has . In reference to falling, she has a couple of times. Sometimes she has in the hospital. The last time she was a week ago. She is much disoriented; they called me during day light, I am not sure at what time, I think it was afternoon."

A review of Resident #2's record showed the resident was admitted , health assessment dated , showed medical history and diagnoses: physical or sensory limitations: blurred vision, decreased hearing. or behavioral status: Moderate precautions. The resident needs assistance with ambulation, bathing, self-care ( ), transferring, and needs supervision with dressing, eating, and toileting.

A review of Resident #2's last progress note on file was dated and documented: Resident #1 apparently shows to be oriented but sometimes she is not. She eats very well. She is recently adjusted with her sister and her son and it is due to her own disorientation. A review of Resident #2's hospital discharge note showed the resident was admitted on for major , recurrent episode, severe.

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	AL11911004	**07/05/2018**
NAME OF PROVIDER OR SUPPLIER **MILLER HEIGHTS HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **4930 SW 87 AVENUE** **MIAMI, FL 33165**	

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Record review revealed the facility did not submit incident reports after Resident #2 . . . at the facility.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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Z828 - Administrative Fines; Violations - 408.813(3) FS

Based on observation, record review, and interview the facility failed to operate within their licensed capacity. The facility is licensed for 6 residents; however, 7 residents were found to be at the facility during survey.

Findings included:

A review of the health finder database revealed the facility is licensed for 6 beds.

On at 7:01 AM arrived to the facility, knocked the door several times and called the facility, the staff reported she would be answering the door. Waited for staff to answered the door until 7:10 AM.

On at 7:10 during facility tour observed in a (not labeled), Resident #5 ambulating with walker. In # observed Resident #4 in bed with half (½) bed rails placed. In # observed Resident #2, observed on the floor. In # observed Resident #3 in bed with ½ bed rails placed and Resident #7 observed to ambulate independently. In # observed Resident #6 in bed with ½ bed rails placed. In # labeled "Employee " observed three size beds. In # the side labeled "storage " had a size bed.

On At 7:21 AM observed outside of the home a . Observed Resident #1 in bed with and with ½ bed rails placed. Resident's son was in the .

On at 7:22 AM Resident #1 stated, "I have been living here since of this year. I am in bed, because my . I manage my own medication and the home health comes Monday through Sunday for bathing and dressing. The ALF sometimes provides meals. I pay 1,000 for rent, my son visits for a couple of days."

Record review revealed the facility did not not provide any records for Resident #1. The facility also did not provide a lease or contact for the .

A Review of Resident #1's home health record on documented: Skilled Nursing frequency 60 days. Skilled Nurse to provide care to non-PRS chronic multiple sites. Surrounding skin reddish, no odor with a large amount of drainage of thin consistency. care as follow: Clean with normal 0.9% , dry, apply cream, cover with dry dressing (4X4) and secure with tape using universal precaution, , technique, control and proper waste disposal. Skilled nurse to instruct patient/caregiver on S/S of to report to physician and the

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skilled nurse on case; such as chills, ... and increasingly painful. Skilled nurse to report to physician S/S of . . . . . Home Health Care Plan & Frequency: 2 day 60 Days. Aide to assist patient with personal care and Activities of Daily Living, Take Vitals signs (Temperature, pulse and . . , ...) in each visit. Assist with patient's personal care each visit. Following standard/universal precaution: Provide assistance with dressing, check pressure areas, foot care, nail care, oral hygiene/ . . . . care. Bathing (bed bath), assist with hair care/comb hair (shampoo weekly); incontinence care, record of bowel. Assist with ambulation. Transfer, and range of motion EX's Provide assistance for light housekeeping, making bed, and changing linens weekly as needed.

Unclassified