STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968963	**09/04/2018**
NAME OF PROVIDER OR SUPPLIER **LITTLE HAVANA LIVING LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2028-2030 NW 5 ST** **MIAMI, FL 33125**	

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

0000 - Initial Comments

A complaint survey (CCR# 2018011696 and #2018012653) was conducted on , 2018. Little Havana Living Llc with limited mental health component (License #12839) 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 record review and interview, the Assisted Living Facility failed to maintain a written record that was updated when one out of 11 sampled residents had a change resulting in the provision of additional services (#2).

Findings included:

On at 11:22 AM, the Administrator stated that Resident #2 had an appointment with the surgeon. The transportation was late and he did not want to go. The resident was supposed to schedule it but he did not do it. The facility reminded the resident, but he was independent for arranging his appointments. The facility arranged the transportation. The resident had a in the . He was going to the doctor for that. The resident was taking for that but was no longer taking them. Staff did document when he refused the medication, but not that they contacted the doctor.

Review of Resident #2's record revealed that there was an after visit summary from showing that on at 3:30 PM the resident would have a surgery. There were no progress notes or observation log for the resident.

Class III

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

Based on record review and interview, the Assisted Living Facility failed to immediately update the Medication Observation Records (MORs) for three out of 11 sampled residents each time the medication was offered or administered (#1, #2, and #3). The facility failed to ensure that MORs included the name of the resident's health care provider and the health care provider's telephone number for two out of 11 sampled residents (#3 and #5). The facility also failed to document in the section in the MORs for two out of 11 sampled residents (#5).

Findings included:

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Review of Resident #1's MORs revealed there was an order for Voltaren 1% gel 100 gm- apply to left knee 3 times a day. It was scheduled at 8 AM, 2 PM and 8 PM. The staff initialed the MORs. There was an order for [illegible] 100 mg tab- take one tablet by mouth at bedtime. It was schedule at 8 PM. The staff did not initial the [illegible] for 8 PM on [illegible].

Review of Resident #2's MORs revealed there was an order for MAPAP 650 mg cap to take one tablet by mouth every 6 hours. It was scheduled at 8 am, 12 pm, 4 pm and 8 pm.

Review of Resident #3's MORs revealed there was an order for Thirehyphenidyl 2 mg- take one tablet by mouth twice a day. It was schedule at 8 AM and 8 PM. [illegible] 20 mg- take one tablet by mouth one time a day. It was schedule at 8 PM. Sustiva 600 mg - take one tablet every day. It was schedule at 8 PM. Isentress 400 mg - take one tablet by mouth every 12 hours. It was schedule at 8 AM and 8 PM. Voltaren 1% apply 2 grams four times a day to the affected area. It was schedule at 8 AM, 12 PM, 4 PM and 8 PM. [illegible] ER 200 mg- take one tablet every night with [illegible] 400 mg . It was schedule at 8 PM. [illegible] ER 400 mg- take one tablet every night with [illegible] 200mg. It was schedule at 8 PM. [illegible] 15 mg- take one tablet twice a day. It was schedule at 8 AM and 8 PM. [illegible] 100 mg- take one tablet in the morning every day. It was schedule at 8 AM. On [illegible] at 8 AM, Staff did not initial the MOR for [illegible] and [illegible]. The staff did not initial the medications for 8 PM on [illegible].

Record review showed that Residents #3 and #5's MORs did not show the physician's name and phone number.

Record review showed that Resident #5's MORs [illegible] section was blank.

On [illegible] at 10:07 AM, Staff C revealed that she assisted the 12 residents with medications. She applied a little of Voltaren to Resident #3 but she did not measure it. She did not know how much were 2 grams of Voltaren.

Class III

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

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

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SUMMARY STATEMENT OF DEFICIENCIES
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Findings included:

On at 7:48 AM, Resident #1 walked out of the a box of Voltaren cream in her hands.

Review of Resident #1's MORs revealed there was an order for Voltaren 1% gel 100 gm- apply to left knee 3 times a day. It was scheduled at 8 AM, 2 PM and 8 PM. The staff initialed the MORs.

On at 10:07 AM, Staff C revealed that Resident #1 did not allow anyone to apply the cream. She applied the cream by herself in the then returned to the staff.

Review of Resident #1's Health assessment (AHCA form 1823) completed on showed that the resident needed assistance with self-administration of medication.

On at 7:53 AM, there were medications at the top of chest in # . Medications were: , and Nighttime &Flu multi-symptom relief. Residents #2 and #6 slept in # .

Review of Resident #2's Health assessment (AHCA form 1823) completed on showed that the resident needed assistance with self-administration of medication.

Resident #2's admission date was on . The agreement signed on ; it showed that facility provided assistance with self-administration of medications, and central storage of all medications including OTC.

Review of Resident #6's Health assessment (AHCA form 1823) completed on that the resident needed help taking her medications but it did not specify if it is assistance with self-administration of medications or administration of medication.

Resident #6's admission date was on . The agreement signed on ; it showed that facility provided assistance with self-administration of medications, and central storage of all medications including OTC.

On at 10:55 AM, the administrator revealed that Resident #2 went out and bought stuff. The resident probably bought medications during the weekend.

Class III

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

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SUMMARY STATEMENT OF DEFICIENCIES
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Based on record review and interview, the Assisted Living Facility failed to follow doctor orders for one out of 11 sampled residents (#2). The facility failed to obtain clarification for medications ordered as needed for one out of 11 sampled residents (#3). The facility also failed to report to the health care provider about the resident's noncompliance with ordered medication for one out of 11 sampled residents (#4).

Findings included:

Review of Resident #2's Medication Observation Records (MORs) revealed there was an order for MAPAP 650 mg cap- take one tablet by mouth every 6 hours. It was scheduled at 8 AM, 12 PM, 4 PM and 8 PM. The staff did not initial the medication for 8 PM on was not initialed.

Review of Resident #3's Medication Observation Records (MORs) revealed there was an order for 50 mg- take one tablet every night as needed. It was schedule as needed and at 8 PM; staff initialed at 8 PM on and , 500 mg- take one tablet by mouth twice a day as needed. There was an order for Smooth as needed.

On at 10:03 AM, the administrator revealed that none of the staff were licensed staff.
On at 10:07 AM, Staff C revealed that staff assisted the 12 residents with medications.

Review of Resident #4's Medication Observation Records (MORs) revealed there was an order for Dou Liquid 50 mg/5 ml - give 20 ml by oral route once a day. It did showed in the back of the MORs that the resident refused to take the medication , , and .

On at 10:34 AM, the administrator revealed that facility contacted the primary physician when the resident refused a medication for two or three days in a row. In the case of Resident #4, she did not want to take the medication in liquid. Facility informed the resident that she needed to talk to her doctor and informs about it. Facility still has not fixed the problem.

Class III

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

Based on observation and record review, the Assisted Living Facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period.

Findings included:

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On at 7:42 AM, Staff C revealed that revealed that there were two staff on duty, Staff C and D, and Staff F was night shift and was leaving.

On at 7:42 AM, Staff C opened the facility's main door. Staff D served breakfast and Staff F assisted residents.

Staff schedule posted on the bulletin board on at 9:26 AM showed that it covered through
Staff C worked Mondays, Tuesdays, Wednesdays, Thursdays, and Fridays from 7 AM to 4 PM. Staff D worked Mondays, Tuesdays, Wednesdays, Thursdays, and Fridays from 7 AM to 6 PM. Staff E worked Tuesdays, Thursdays, from 6 PM to 7:30 PM, and Saturdays and Sundays from 4 PM to 7:30 AM. Staff F worked Mondays, Wednesdays, Fridays, from 6 PM to 7:30 PM, and Sundays from 7:30 AM to 4:30 PM. The administrator worked Sundays from 7:30 AM to 4:30 PM. The owner worked Saturdays from 7:00 AM to 4:00 PM.

On at 9:26 AM, the Administrator revealed that a new schedule was not in placed due to the long weekend.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC

Based on record review and interview, the Assisted Living Facility failed to ensure that unlicensed staff complete an additional 2 hours of assistance with the self-administration of medication and medication management for four out of six sampled staff after the rule update (Staff C, D, E and F).

Findings included:

On at 10:03 AM, the Administrator stated that none of the staff were licensed staff.

On at 10:07 AM, Staff C stated that staff assisted the 12 residents with medications.

Review of Staff C's personnel record showed that the hire date . She had 4 hours medication training on and on .

Review of Staff D's personnel record showed that hire date was on . She had 4 hours

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medication training on and on .

Review of Staff E's personnel record showed that hire date was on . She had 4 hours medication training on and on .

Review of Staff F's personnel record showed that hire date was on . She had 4 hours medication training on and on .

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 prepare and serve therapeutic diet as ordered by the health care provider for one out of 11 sampled residents (#6).

Findings included:

On at 12:14 PM, Staff D served lunch to Resident #6 in the dining . Resident #6's lunch had regular consistency. Lunch was mixed vegetables, mixed salad, boiled potatoes, baked chicken and peaches.

Review of Resident #6's record showed that admission date was . Health assessment (AHCA form 1823) completed on . The resident needed supervision eating, and special diet section showed soft mechanical diet.

On at 2:15 PM, the Owner asked the Administrator for a new health assessment for Resident #6. There was no other health assessment for Resident #6.

Class III

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

Based on observation and interview, the Assisted Living Facility failed to provide minimum furniture requirements for each resident failed to ensure that items were in good repair.

Findings included:

On at 7:53 AM # smell . There was no closet. Walls in the multiple white

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patches, they were no painted.
On at 7:56 AM, there were four boxes and three luggage in # and it did not have closet or wardrobe. Resident # 8 rested on a bed in # .
On at 7:58 AM, the closet in # did not have doors. There was a gray patch next to one of the window and a hole under the same window. One of the blinds was broken.
On at 8:01 AM, # did not have a closet or wardrobe. Hangers were in the one of the door knob. There was a luggage in one of the corner and shoes at the top of the chest.

On at 2:11 PM, the owner revealed that the resident from # was discharged and they stored her belongings in that . At 2:14 PM, the owner revealed that facility provided furniture to residents. She ordered the door for the closet of # . The hole happened during the weekend.

Class III

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

Based on record review and interview, the Assisted Living Facility failed to document the source of admission for two out of 11 sampled residents (#2 and #6). The facility also failed to have the reason for discharge and identification of the address to which the resident was discharged documented on the log for two out of 11 sampled residents (#9, #10 and #11).

Findings included:

Review of the admission and discharge log revealed that Resident #2's admission date was . Resident #6's admission date was . There was no documentation about the place from which the residents were admitted.

Record review revealed the admission and discharge log did not have the reason for discharge or identification of the facility to which Resident #9 was discharged. Resident #9's admission date was and discharge date was .

Record review revealed the admission and discharge log did not identify the facility where Resident #10 was discharged to. Resident #10's admission date was and discharge date was .

Record review revealed the admission and discharge log did not identify the facility where Resident # 11 was discharged to. Resident #11's admission date was and discharge date was .

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On at 9:55 AM, the Administrator stated he was not sure about the discharge information because he was not working at that time and said that was the most updated admission and discharge log.

Class III

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

Based on record review and interview, the Assisted Living Facility failed to have complete health assessments for two out of 11 sampled residents (#2 and #6). The facility also failed to have a weight record initiated on admission for one out of 11 sampled residents (#2). The facility also failed to have evidence of distribution of residents fund for two out of 11 residents

Findings included:

1. Review of Resident #2's Health assessment completed on showed that , weight and height sections were blank. The resident needed assistance with ambulation, bathing, dressing, self-care ( ), and transferring, supervision for toileting and independent for eating.

Review of Resident #6's Health assessment (AHCA form 1823) completed on showed that the resident needed help taking her medications but it did not specify if it is assistance with self-administration of medications or administration of medication. The resident needed assistance with bathing, dressing, self-care, and toileting.

2. Weight log for Resident #2 was blank. Weight log for Resident #6 was blank.

3. On at 10:57 AM, the Administrator stated that Residents #6 and #7 received (,).

Review of Resident #1's record showed a notice of case action stating that the resident's application was approved effective . It was mailed to the facility's address. The resident's fund log was blank.

Review of Resident #7's record showed that the residents fund log was blank.

On at 11:58 AM, the Owner stated that Residents #1 and #7 received . She further stated that she bought things that Resident #1 needed with that money. To Resident #7, she gave the money, but she claimed that the resident could not sign. At 12:11 PM, the Owner revealed that facility did not

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receive the . . . for Resident #7, and that Guardianship received it and they sent the extra money sometimes.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation and record review, the Assisted Living Facility failed to maintain enough fuel at all times when the facility is occupied to run the generator for 48 hours.

Findings included:

On . . . . . at 2:30 PM, observed that the facility had 10 gallons of gas.

Review of facility's emergency power plan revealed that facility will store 10 gallon gas. A review of the manufacturer's instructions showed that the generator would run for 10 hours with 8 gallon of gas.

Class III