STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11912063	**09/24/2018**
NAME OF PROVIDER OR SUPPLIER **MAGGIE'S RETIREMENT HOME #4**	STREET ADDRESS, CITY, STATE, ZIP CODE **7100 NW 1 TERRACE** **MIAMI, FL 33126**	

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

0000 - Initial Comments

A Standard Biennial Survey was conducted on , 2018. Maggie's Retirement Home # 4 ALF (License # 7978) with Extended Congregate Care and Limited Mental Health components had deficiencies identified at the time of the survey:

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on observation, record review, and interview the facility failed to ensure that one out of 10 sampled residents (# 1) met admission criteria.

Findings included:

On at 8:23 AM observed Resident #1 in bed in # lying in bed.

On at 8:23 AM Staff D stated, "Resident #1 is on hospice."

Review of Resident #1's record revealed she was admitted to the facility on . Resident #1 started receiving hospice services on . Review of the hospice's nurse admission note revealed that the resident was totally dependent for activities of daily living on the day of admission.

On at 10:35 AM Staff B stated Resident #1 was total care when she was admitted. They placed her under hospice before bringing her to the assisted living facility because she needed to have the medications administered and that they thought that having the extended congregate care component was enough to admit the resident.

Class III

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

Based on record review and interview the facility failed to have a signed consent form for the use of side rails for one out of 10 sampled residents (# 1).

Findings included:

During tour of the facility on at 8:23 AM observed Resident #1 in bed in # lying in bed with full side rails up.

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Review of resident #1's record revealed there was a prescription for full side rail dated [redacted] from hospice. The facility failed to have a consent for half bed rail signed on [redacted].

On [redacted] at 10:58 AM Staff B stated, "I will have the family sign the consent for full side rail."

Class III

0052 - Medication - Assistance with Self-Admin - 429.256(3-4); 58A-5.0185 (3)

Based on observation and interview the facility failed to follow the correct procedure outlined by the state when assisting with self-administration of medications one out of 10 sampled residents (# 1).

Findings included:

On [redacted]18 at 8:40 AM observed Staff D assisted Resident #1 with self-administration of medications. Staff D punch the medications out of the [redacted] cards and placed the medications with her bare hands into the medication cup.

On [redacted] at 8:45 AM Staff D stated, "Every time you come you always tell me the same."

Class III

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

Based on record review and interview the facility failed to keep an accurate medication observation record for one out of 10 sampled residents (#1).

Findings included:

Review of Resident #1's record revealed that she was [redacted] to [redacted]. Review of the medication observation record revealed that the [redacted] section stated, "No Known [redacted]."

On [redacted] at 10:10 AM Staff B stated that she will update the medication observation record for Resident #1.

Class III

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SUMMARY STATEMENT OF DEFICIENCIES
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0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on record review and interview the facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period

Findings included:

Review of the bulletin board revealed that the staffing schedule was not posted.

On at 9:05 AM Staff B Stated, "The owner is bringing it. We were making copies at the other facility."

Class III

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

Based on observation and interview the facility failed to keep a 3 day-supply of non-perishable food on hand at all times for a census of 10 residents.

Findings included:

During tour of the facility on at 8:25 AM observed that there was emergency food in a shed in the patio. There were only a loaf of bread and a few cans, frozen food were observed but are not considered non-perishable were stored in the area.

On at 8:50 A Staff B stated they keep the food at the other facility because the storage there was better than at this facility and that she brought the food every week to the facility.

Class III

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

Based on record review and interview the facility failed to have an accurate health assessment for one out of 10 sampled residents (#1). The facility also failed to keep an order for third party services on file for one out of 10 sampled residents (#1).

Findings included:

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SUMMARY STATEMENT OF DEFICIENCIES
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Review of Resident #1's record revealed she had been receiving hospice services since . . . . . The last health assessment was completed on and stated that the resident required assistance with activities of daily living, was under hospice services, did not have , ... , and required assistance with self-administration of medications. The hospice care plan was reviewed on stated Resident #1 had a . . . , ... in the sacral area and an untraceable , ... in the right heel and required total assistance with activities of daily living. Resident #1 was also receiving home health services for administration on . . . . twice a day, the facility did not have any order for the administration by the home health agency.

On at 9:20 AM the registered nurse (RN) from hospice stated Resident #1 received care daily with triple . . . . . because she was . . . to . . . . She stated that the resident came from the hospital under hospice services, total care, and had a , on the right heel but the sacral , ... had developed last week. Review of the home flow sheet from hospice revealed that the sacral developed on . Review of the hospice nurse admission note revealed that the resident was totally dependent for activities of daily living on the day of admission.

On at 10:05 AM The RN from hospice stated, "She came from the hospital with the . . . on the right heel."

On at 10:35 AM Staff B stated Resident #1 was total care at admission time and they placed her under hospice before bringing her to the assisted living facility because she needed to have the medications administered and that they thought that having the extended congregate care component was enough to admit the resident.

On . . . . at 11:05 AM Staff B stated that she would get the prescription for home health for Resident #1.

Class III

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(9) FAC

Based on record review and interview the facility failed to ensure that staff receive an initial limited mental health training within 6 months of being hired for one out of five sampled (Staff C).

Findings included:

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Personnel record review revealed Staff C was hired hired on . . . . . and she did not have the initial limited mental health training.

On . . . . . at 11:20 AM Staff B stated that she would make an appointment for Staff C to go complete the initial limited mental health training.

Class III