STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910951	R 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE LIVING IN HIALEAH LLC	**70 EAST 21ST STREET** **HIALEAH, FL 33010**

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

0000 - Initial Comments

A Biennial Survey revisit was conducted on . . . . . Divine Living In Hialeah license #7170, with a limited mental health component, had deficiencies identified at the time of the survey:

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

Based on observation, record review and interview, the facility failed to honor on one of 76 sampled residents' rights to be free of . . . (Resident #21). The resident was restricted to bed by a locked bed rail and a wheelchair which the resident could not remove.

Findings included:

On at 6:43 am, Resident #21 bed was observed with a locked half bed rail and wheelchair used as a barrier to prevent the resident from exiting.

On . . . , a review of Resident #21's file revealed no documentation of a physician's order for bed rails.

On at 9:05 am Staff I stated she was unaware the half bed rail was being locked in place and had no knowledge of the wheelchair being used as a barrier. Staff I confirmed Resident #21 did not have a bed rail order in his file and said she would have to request it to be faxed to the facility at that time.

On at 9:57 am, Staff I was able to present a faxed copy of a bed rail order for Resident #21 and confirmed the half bed rail was being utilized incorrectly.

Class III

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

Based on observation and interview the facility failed to ensure that the Medication Observation Records (MOR) for 18 out of 18 residents that received assistance with self-administration of medications. (Residents 4,11,13,20,21,22,23,27,28,29,30,31,32,33,34,35,36,37)

Findings Included:

Observation on , at 7:05 am showed Employee M signing the MORs prior to giving

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residents the medication. (Residents 4,11,13,20,21,22,23,27,28,29,30,31,32,33,34,35,36,37)

On , Employee M stated she did not think it was a problem to sign the MORs before giving the medication.

Class III

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

Based on observation and interview, the Assisted Living Facility failed to keep prescribed medication for five of 76 sampled residents, (Residents #15, 23, 24, 25, and 27) securely stored and out of the reach of all residents at the facility.

Findings included:

On at 9:28 am, prescribed medication was observed in the main office computer drawer. The entrance to the main office and computer drawer remained unlocked throughout the survey, and residents were observed opening the door and entering the office, unaccompanied by staff.

On at 9:40 am Staff L stated the medications found in the computer drawer were to be returned to the pharmacy. Staff L stated the medications to be returned were usually kept in a separate office that is always locked. Staff L stated she does not know why the medications were located in the main office and confirmed prescribed medications were accessible to all residents in the facility.

Class III

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

Based on observation, interview and record review the facility failed to adhere to medication orders for 2 out of 3 residents. (Residents 20 and 4).

Findings Included:

On , at 9:21 am Employee M stated that the medications were usually given between 7 am and 9 am.

On , at 9:09 am interviewed Resident 4. She reported her medications were due at 8:00 am and she did not received the medications. At 9:18 am observed Resident 4 waiting in line to receive

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SUMMARY STATEMENT OF DEFICIENCIES
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her medications. At 9:20 am observed Employee M giving resident the medications.

Review of Medication Observation Record showed Resident 20's medications ordered to be given on , at 8:00 am. At 9:21 am Employee M was observed giving the medication.

On , at 9:45 am Employee I stated Employee M was a new employee and it took her longer to give residents their medications.

Class III

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

Based on observation and interview, the facility failed to maintain appurtenances in good working order.

Findings Included:

Observations made on at 6:50 am showed paint peeling from the doors and walls. Several dining room chairs were broken. The upstairs ceiling tiles had brown spots. A bathroom window broken.

On , at 9:45 am Employee I stated she was not aware, and would tell the maintenance person.

Uncorrected
Class III