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	AL11965091	**11/09/2018**
NAME OF PROVIDER OR SUPPLIER **MARILIN ADULT LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **7312 SW 16 STREET** **MIAMI, FL 33155**	

SUMMARY STATEMENT OF DEFICIENCIES
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Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on observation, record review, and interview, the facility failed to have an eligible level II background screening for two of nine sampled staff prior to providing direct care and services to a census of seven residents (Staff B and Staff C).

Findings included:

Arrived at the facility on at 6:00 AM Staff B answered the door. Staff C was observed in her sleeping in her room. The facility had a census of seven residents. At 6:39 AM on observed Staff B administered medications to Resident #5.

A review of the background screening database on showed no eligible background screening result for Staff B and C.

Review of the facility's personnel file on revealed that Staff B and C did not have a file available for review.

During an interview on at 6:55 AM, the Administrator stated "Staff C is new, no tiene file (she does not have a file)."

Unclassified

Z828 - Administrative Fines; Violations - 408.813(3) FS

Based on observation, record review, and interview, the facility failed to obtain a licensure capacity increase prior to providing personal care and meals to a census of seven residents. The facility provided services to residents outside its current license capacity of six.

Findings included:

During the facility's tour on at 6:00 AM, seven residents were observed with a total of seven beds. Resident #7 was observed sleeping on a hospital bed with full side rails.

A review of the facility's records on revealed that six residents were listed on the facility's admission and discharge log. However, Resident #7 admitted on was listed as discharged on .

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On ..... at 8:35 AM, the hospice nurse aid stated that she was in the facility bathing Resident #7 because resident was put on hospice only yesterday .

In an interview on at 9:15 AM, Resident #6 stated "The same amount of residents that you see here are the same amount of residents that are in this place all the time."

On ..... at 9:40 AM during an interview, Resident #5 stated "We are always the same amount of people living in this place."

Unclassified

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0000 - Initial Comments

A Complaint Investigation (CCR 2018013481) Survey was conducted on and concluded on . Marilin Adult Living Facility, license #9548 had deficiencies at the time of the investigation.

0004 - Licensure - Requirements - 58A-5.016 FAC

Based on record review and interview, the facility failed to provide documentation of a satisfactory annual sanitation inspection.

Findings included:

Posted on the wall was the health inspection dated , expired on . The facility did not have proof of the current health inspection available for review.

In an interview on at 10:30 AM, the Administrator acknowledged that the facility did not have a current health inspection.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on observation, record review, and interview, the facility used physical , full bed rails, for one out of eight sampled residents (Resident #4) and failed to have a consent for bed rails for two out of eight sampled residents (Residents #3 and #7).

Findings included:

On around 6:00 AM, observed Resident #4 and #7 each on a hospital bed with full side rails. Also, observed Resident #3 in a hospital bed with half side rails.

A review of Resident #4's file on showed an order for full rails dated and a signed consent for half rails dated . Further review of Resident #3's revealed that the facility did not have a signed informed consent to the use of half side rails in file for Resident #3.

Review of Resident #7's file showed a signed consent for half bed rails dated and the facility did not have an order from a health care provider for a hospital bed with full side rails available.

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During an interview on around 11:53 AM, the Administrator acknowledged the findings.

Class III

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

Based on observation and interview the facility failed to ensure that centrally stored medications were secured for the residents and ensure that medications were locked up for one out of eight sampled residents (Resident #4)

Findings included:

Observed an unlocked cabinet on , at 6:10 AM with stored medications for the residents.

In an interview with Staff B she stated she forgot to lock the medication cabinet.

Observed an open closet on at 6:23 AM with over the counter medications for Resident 4.

In an interview with Employee I on at 12:07 PM he stated the resident's family bring in medications without informing the staff.

Class III

0077 - Staffing Standards - Administrators - 429.176 FS; 429.52( ),58A-5.019(1) FAC

Based on observations, record review, and interview, the facility failed to have an administrator who was responsible for the operation and maintenance of the facility, including the management of all staff and the provision of appropriate care to all residents (Residents #). The facility had seven residents, over is licensed capacity of six. Staff B and C were left alone in the facility with a census of seven residents although they did not have an eligible level 2 background screening, First Aid or , , ( ), or other required training. The facility's administrator failed to have interventions in place that would prevent two out of eight residents from sustaining with (Residents #7 and #8).

Findings included:

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1) On at 6:00 AM Staff B answered the facility's door and assisted with touring the facility. Staff C was observed sleeping in her room. Seven residents were observed with a total of seven beds. Resident #7 was sleeping on a hospital bed with full side rails.

On at 8:35 AM, the hospice nurse's aid stated that she was in the facility bathing Resident #7 because resident was put on hospice only the day before ( ).

On at 6:39 AM, observed Staff B punched a pack in a small cup on the dining room table; then, Staff B took the medications cup with a cup of water to room number #3. Upon arriving in the room, Staff B raised the of the bed and tried to put the medications cup in Resident #5's . Resident #3 stated "dame un poquito de agua, (give me some water)." Staff B put the cup of water in the resident's then put the medication in the resident . Staff B then went to the dining room and sign the Medication Observation Records (MOR).

Medication reconciliation revealed Staff B administered , 112 mcg tablet , take 1 tablet by in the morning to Resident #5.

In an interview on around 6:40 AM, Staff B stated "yes, I give her this medication every morning."

On at 9:00 AM Resident #1 stated "My medication usually I get it from Staff B, but today I got it from Staff D."

On at 9:15 AM Resident #6 stated "Staff B and Staff C are the two people who stay with us at night and sometimes they give me my medication and other times the ladies that come during the day."

On at 9:40 AM Resident #5 stated "Staff B is the one who usually gives me my medication every single day."

A review of the facility's MOR on , showed that Resident #1's MOR sheet was signed for as given on . No notes were written on the of the MOR. Medication reconciliation revealed that 20 mg tablet was in the pack dated . Resident #1 did not receive on . Further review, revealed that Resident #7's MOR sheet was not in the medication log.

During an interview on at 11:00 AM the Administrator stated that Resident #7's MOR sheet was in a room. The administrator brought the MOR a few minutes later. Resident #7's MOR sheet dated

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was signed from to for medications given that period of time and was falsified from to . The letter "H" (meaning that Resident #7 was in the hospital and did not receive assistance with self-administration of medication) was written over the signature for medication given on , , and . There were no other notes written on the of the MOR.

Review of the facility's personnel file on revealed Staff B and C did not have a file available for a review. A review of the background screening database on showed no eligible background screening result for Staff B and C. The facility failed to provide documentation that Staff B and C (who were left alone with the residents) had First Aid and , control training, training, and medication training.

During an interview on at 6:55 AM, the Administrator stated "Staff C is new, no tiene file (she does not have a file)."

On at 9:25 Staff D stated "Staff B and C have been working in this place for a few months already. They assist the residents with their medication when needed."

On at 9:33 Staff E stated "Staff B and C have been working in this place for over two months I think. They stay in the facility to take care of the residents sometimes."

On at 10:33 AM a resident family member stated "Staff B and C are the caregivers who work in this place for over a year I think and they are the ones who provide the assistance and medication to all of them.

2) Review of the resident's files on revealed the following:

Resident #1's health assessment dated showed her diagnoses and medical history were , Osteoarhtits , , Airway , and . The resident was wheelchair bound. She needed assistance with ambulation, bathing, , eating, grooming, toileting, and transferring. She needed assistance with self-administration of medication.

Resident #2's health assessment dated showed that her diagnoses and medical history were , , , Dyslipidemia, and . She needed

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assistance with ambulation, bathing, , eating, grooming, toileting, and transferring. Resident #2 was on precautions and needed assistance with self-administration of medication.

Resident #3's health assessment dated was outdated and showed diagnoses and medical history of , Osteoarthrtits , and . She needed precautions and assistance with ambulation, bathing, , eating, grooming, toileting, and transferring. She needed assistance with self-administration of medications.

Resident #4 was a hospice patient, her health assessment dated showed she was diagnosed with Myasthemia , 's , , Osteoarhtits , , Gait , II, , , Dyslipidemia, , Aphasia, and Organic . She needed precautions and assistance with ambulation, bathing, , grooming, toileting, and transferring; and needed supervision with eating. Resident #4 needed assistance with self-administration of medications.

Resident #5's health assessment dated showed that her diagnoses and medical history were " , and Mild . She needed precautions and assistance with ambulation, bathing, , eating, grooming, toileting, and transferring. She needed assistance with with self-administration of medications.

In an interview on at 4:11 PM Resident #5's family member sated that the resident was admitted to the facility on and on that same night and was taken to a local hospital. The family member added that the Resident had a and stayed in the hospital for a couple of weeks. From to she was in rehabilitation. A few months ago he had a problem with a caregiver because his mother told him that this caregiver was abusing her verbally and he talk to the owner and he told them that he was going to move her our and then the Administrator, told him not to worry that she was going to take care of this. What the owner did was to move this caregiver to Richland ALF, another ALF of the same owners. Also he stated that a few months ago, probably two months, the facility had eight residents, the eight resident was Resident #8, she was a resident who lived in the facility for almost two years but she was removed from the facility by her daughter because she found that her mother had a on her .

Resident #6's health assessment dated showed her diagnoses and medical history were Osteoarhtits , , Poor Balance, Restricted Motion, , or , and . She needed precautions and assistance with ambulation, bathing, , eating, grooming, toileting, and transferring. The resident needed assistance with self-administration of medications.

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Resident #7's health assessment dated showed that her medical history and diagnoses were Osteoarhtits , and . She needed precautions. Resident #7 needed assistance with ambulation, bathing, , eating, grooming, toileting, and transferring. She needed assistance with self-administration of medications.

In an interview on at 10:25 AM, the Administrator stated " Resident #7 was admitted to the hospital in . She down in the facility while her daughter was visiting and she was sent to the hospital, and after that she went to a rehabilitation center. " She added "Resident #7 came to the facility last night . I accepted her because the daughter did not want to go to another ALF anymore."

Review of Resident #7's hospital record dated on stated "patient was brought via Emergency Medical Services for slip and . Patient coming from and Assisted Living Facility. Patient reports , to and right , and right ." General assessment stated "patient is a risk." Associated Diagnoses stated "Closed Injury (CHI) with left . History of present illness stated came by ambulance form the Assisted Living Assistance where she lives. She was walking with her walker and made a sudden turn and on her right side. She injuring her right , . She struck her however she did not lose . The patient was left on the floor until the paramedics arrived. She offered no complaint with respect to , when Emergency Medical Services arrived. She comes to the Emergency Department accompanied by her family."

A review of the facility records on revealed that Resident #5 and #7 did not have progress notes available for a review.

Further review of the residents' file on revealed that the facility did not have progress notes available for a review for Resident #1, #3, and #4. Review of Resident #2's record revealed that the last progress notes completed by the facility was dated .

In an interview on On at 4:53 PM Resident #8's family member stated, that "the resident was admitted to the facility on and on , she during the night and she was taken to a local hospital. The thing is that after she she never was the same. She went to the facility walking, getting minimal assistance and when she left the facility she needed assistance for everything and she could not walk." The family member added that a few months ago she went to visit Resident #8 and found out that she (the resident) had a on her and had high temperature, when she asked the a staff member in the facility about Resident #8's condition, the staff stated that she (the staff)

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had notice that and was going to report it to the administrator. Then, the family member called the rescue and Resident #8 was taken to a local hospital. The family member stated that the doctor told her that the was caused by a or a hit that the resident may had a few days prior.

Review of Resident #8's hospital record dated on showed "history of present illness: the patient presents following . The onset was just prior to arrival. The occurrence was single episode. The was described as tripped, lost balance. The location where the incident occurred was at home. Location:left , . The character of symptoms is , . Impression: and displaced left , . The addendum hospital record dated stated " , female past medical history of , , T2 , replacement presents to the hospital as a sustaining at the Assisted Living Facility where she resides. Patient was unable to stand from ground. Fire rescue was called and transferred the patient to the hospital emergency department for further evaluation. A the time of the examination, the patient's left is shortened in comparison to the right. Left is also mildly externally rotated."

Class II

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC 429.52 (6), FS

Based on interview and record review the facility failed to ensure three out of nine sampled employees successfully completed the 2 hour of continuing education training with providing assistance with self-administrated medications (Staff D,G,H).

Findings included:

Review of Staff D, G, and H files showed no documentation of the 2 hours continuing education training on providing assistance with self-administered medications.

In an interview with the Administrator on at 12:05 PM she stated she thought everyone had the appropriate training.

Class III

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

Based on observation, record review, and interview, the facility also failed to have updated health assessment for one out of eight sampled residents (Resident #3). The facility failed to have updated

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plans of care for one out of eight sampled residents (Resident #4).

Findings included:

During the facility tour on around 6:00 AM, observed Resident #3 in a hospital bed with half side rails.

A review of the residents' file on revealed that Resident #3's health assessment dated was expired on .

During an interview on at 11:53 AM, the Administrator acknowledged the findings.

A review of Resident #4's hospice file revealed that the resident was admitted to hospice on and the last two Plan of Care were dated and . There were no plan of care for the month of , .

During an interview on around 12:00 PM, the Administrator acknowledged the findings that the facility did not have the updated records.

Class III

0163 - Records - Resident, Penalties for Alteration - 429.49 FS

Based on record review and interview, it was determined that the facility falsified resident a record for one out eight sampled residents (Resident #7). Review of the facility's Medication Observation Record revealed that it was falsified.

Findings included:

A review of the facility's MOR on revealed that Resident #7's MOR sheet was not in the medication log.

During an interview on at 11:00 AM the Administrator stated that Resident #7's MOR sheet was in a room.

The administrator brought the MOR a few minutes later. Resident #7's MOR sheet dated was signed from to for medications given that period of time and was falsified from

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to . The letter "H" (meaning that Resident #7 was in the hospital and did not receive assistance with self-administration of medication) was written over the signature for medication given on , , and . There were no other notes written on the of the MOR.

Class III

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

Based on record review and interview, the facility failed to complete and submit 1 day initial adverse incident report and 15 day full incident report to the agency for two out of eight sampled residents who in the facility, was transported to the hospital and had (Residents #7 and #8).

Findings included:

Review of Resident #8's hospital record dated on stated "history of present illness: the patient presents following . The onset was just prior to arrival. The occurrence was single episode. The was described as tripped, lost balance. The location where the incident occurred was at home. Location:left , . The character of symptoms is , . Impression: and displaced left , . The addendum hospital record dated stated " female past medical history of , , T2 , replacement presents to the hospital as a sustaining at the Assisted Living Facility where she resides. Patient was unable to stand from ground. Fire rescue was called and transferred the patient to the hospital emergency department for further evaluation. A the time of the examination, the patient's left is shortened in comparison to the right. Left is also mildly externally rotated."

In an interview on On at 4:53 PM Resident #8 family member stated that "the resident was admitted to the facility on and on , , she during the night and she was taken to a local hospital. The thing is that after she she never was the same. She went to the facility walking, getting minimal assistance and when she left the facility she needed assistance for everything and she could not walk." The family member added that a few months ago she went to visit Resident #8 and found out that she (the resident) had a in her and had high temperature, when she asked the a staff member in the facility about Resident #8's condition, the staff stated that she (staff) had notice that and was going to report it to the administrator. Then, the family member called the rescue and Resident #8 was taken to a local hospital. The family member stated that the doctor told her that the was caused by a or a hit that the resident may had a few days prior.

Review of Resident #7's hospital record dated on stated "patient was brought via

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Emergency Medical Services for slip and . Patient coming from and Assisted Living Facility. Patient reports , to and right , and right ." General assessment stated "patient is a risk." Associated Diagnoses stated "Closed Injury (CHI) with left . History of present illness stated , came by ambulance form the Assisted Living Assistance where she lives. She was walking with her walker and made a sudden turn and on her right side. She injuring her right , . She struck her however she did not lose . The patient was left on the floor until the paramedics arrived. She offered no complaint with respect to , when Emergency Medical Services arrived. She comes to the Emergency Department accompanied by her family."

During an interview on at 10:25 AM, the Administrator stated Resident #7 was admitted to the hospital in she down in the facility while her family member was visiting and she was sent to the hospital, and after that she went to a rehabilitation center. The Administrator added "I did not do an incident report because I thought that she was not going to come to this place anymore, but still I kept collecting the payment."

Record review found the facility did not submit incident reports for Residents #7 and #8 after the residents and sustained .

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on record review and interview, the facility failed to notify each resident and the resident's legal representative in writing about its Emergency Power Plan (EPP) and the facility also fail to have monoxide detectors working properly at the time of the survey.

Findings included:

A review of the facility's (EPP) record on revealed that it did not have a written proof of notification given to the residents. The facility also failed to have monoxide detectors working properly at the time of the survey.

On at 12:00 PM, the Administrator stated that she knew that these things had not been done as of yet.

Class III