STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967492	R 01/02/2019
NAME OF PROVIDER OR SUPPLIER **ALWAYS LOVING FAMILY CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **4394 SW 151 PLACE** **MIAMI, FL 33185**	

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

0000 - Initial Comments

A Standard Biennial Revisit Survey was conducted on 01/02/19. Always Loving Family Corp., with Limited Mental Health components, had the following deficiencies identified at the time of the survey:

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 failed to honor the resident's rights for one out of five sampled residents (Resident #5).Resident #5 was restrained by a dresser which she could not remove, which blocked her exit from the bed.

Findings included:

1) On at 7:19 AM, observed Resident #5 rested in bed. The bed had a headboard and a footboard, and was against the wall and had a half-bed rail, raised. There was a dresser against the bed that blocked the open exit from the bed after the bed rail.

Class III
Uncorrected

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

Based on observation and interview, the facility failed to follow the correct procedure outlined by the state when assisting one out of five sampled residents with self-administration of medications (Resident #3) . Staff B did not read the medication label aloud and verbally prompt the resident to take medications as prescribed.

Findings included:

On at 7:45 AM, observed Staff B assist Resident #3 with self-administration of medications. She passed the medications to the resident in a cup but she did not read the medications' label to her.

On at 10:53 AM, the Owner stated that Staff B was probably nervous.

Class III

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

Based on record review and interview, the facility failed to immediately update the Medication Observation Records (MORs) after a medication was offered or administered for two out of five sampled residents (Residents #5 and #3). The facility failed to write on MORs the time for the medications and to identify the [illegible] for two out of five sampled residents (Residents #1 and #2).

Findings included:

Review of Medication Observation Records (MORs) for Resident #5 showed that they had Staff initialed on [illegible] at 6:50 AM for the medications scheduled at 8 AM. Also on [illegible] at 6:50 AM, MORs for Resident #2 were initialed. The MORs for Resident #3 on [illegible] at 6:50 AM showed that there was an order for [illegible] 10 mg tablet take one tablet daily by [illegible]. It was scheduled at 8 AM. The medication was not initialed for [illegible]. Review of MORs for Residents #1 and #2 showed that [illegible] section for both of them was blank. Their medications were just scheduled on "AM and PM".

On [illegible] at 6:50 AM, Staff B revealed that nurse from hospice came early and gave medications to Resident #2. She stated in reference to MORs for Resident #5, "I gave her the medications because she was impatient."

Review of Resident #1's record showed that her last health assessment completed on [illegible]. It showed that the resident had NKDA (No Known Drug [illegible]).

Review of Resident #2's record showed that her last health assessment completed on [illegible]. It showed that the resident had NKDA.

On [illegible] at 8:41 AM, the owner revealed it probably happened because the month just started and everyone was crazy, when she was asked about medications with no schedule time. The owner did not answer when was asked about the [illegible] that was not initialed as given on [illegible]. Then at 8:43 AM, she added that facility always wrote the schedule time for medication and she did not know about documenting the [illegible] in the MORs.

Class III

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

Based on observation, interview and record review, the facility failed to ensure that all medications were

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kept in a locked cabinet, locked cart, or other locked storage receptacle/ room, or area at all times.

Findings included:

On at 6:45 AM, observed that the medication closet's lock was open. There were medications inside for five out of five residents. The closet was on hallway that communicated residents' rooms with living room and dining room.

On at 7 AM, Staff B closed the medication closet. She revealed that they leave it open just while helping with the medication but the rest of the time it was always locked.

On at 7:15 AM, observed medications unsecured in the facility's refrigerator. There was a hospice comfort kit for Resident #1 and #2. Medications were 110 mg suppositories, 0.125 mg tablet, 10 mg tablet, 1 mg tablet, Sulf liquids 100 mg/5 ml, 650 mg tablet, 1 mg tablet, 1 mg liquid, tablet, 0.1 mg tablet, 2 mg/ml, Odt 8 mg tablet.

On at 8:17 AM, observed the medication cabinet was unlocked.

Review of two out of five sampled residents' records showed that Residents #1 and #2 needed medication administration. Two out five sampled residents (Residents #4 and #5) needed assistance with self-administration of medication.

On at 10:53 AM, the owner stated the medications should be locked at all times and that the hospice nurse left the medication box opened in the refrigerator. She further stated that the facility's refrigerator was the only one and that residents had access to it.

Class III

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

Based on observation and interview, the facility failed to provide a safe living environment, free of hazards and failed to maintain appurtenances in good repair.

Findings included:

On at 7:19 AM, Resident #5 laid in bed with linen.

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On [redacted] at 10:55 AM, the owner revealed that staff washed the linens and they knew that linens in bad condition have to be thrown away.

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 five sampled residents (Resident #1).

Findings included:

Review of Resident #1's record showed that her admission date was [redacted]. The last health assessment completed on [redacted] showed that the resident had NKDA (No Known Drug [redacted]). The resident had medical history and diagnoses of [redacted] associated with [redacted] without behavioral disturbances, partial [redacted] with [redacted] partial [redacted]. It showed that the resident was bedridden, required 24-hour nursing or [redacted] care and her needs cannot be met in an assisted living facility.

On [redacted] at 10:55 AM, the owner revealed that the health assessment was incorrect and that the resident did not require 24-hour nursing care. The Owner further stated that the facility would call for medical help if the resident had a [redacted].

Class III
Uncorrected