STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969251	**04/02/2019**
NAME OF PROVIDER OR SUPPLIER **AMERICAN HOME CARE FACILITY INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **6960 SW 155 AVE** **MIAMI, FL 33193**	

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

0000 - Initial Comments

A relicensure survey was conducted at American Home Care on on . . . . . The facility had deficiencies identified at the time of the survey.

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

Based on observation, record review and interview, the Assisted Living Facility failed to ensure that unlicensed person providing assistance with self-administration of medications did so according to the specifications outlined by the state for two out of nine sampled residents (#5, #3, and #2). Staff C did not read the medication label aloud or verbally prompt a resident to take medications as prescribed. The facility failed to ensure that out of nine sampled residents received assistance with self-administration of medication within one hour before or one hour after the scheduled time (#5, #3, and #2).

Findings included:

1. On . . . . at 8:56 AM, Staff C arrived to the dining room with a medications bin for Resident #5.

On . . . . at 8:56 AM, Staff C said in Spanish to Resident #5 "la medicina que te mando el medico, tomatela" It meant in English "this is the medication ordered by the doctor, take it."

On at 9:06 AM, Staff C gave one pill to Resident #5 and she took it to her by herself and swallowed it with apple juice. Staff C did not say aloud the name of the medication to the resident or read the medication label aloud or verbally prompt a resident to take medications as prescribed.

Review of the medication card for Resident #5 showed that the medication that she took was . . . . POT 100 mg tab with an order to take one tablet by . . every day.

Review of Resident #5's Medication Observation Record that she had a medication scheduled at 6 AM. The medication was POT 100 mg tab instructions of taking one tablet by every day.

On at 12:39 PM, Resident #5 revealed that she did not like that the staff did not tell the name of the medications she was taking. She liked to know the name of the medications.

2. On . . . . at 9:25 AM, Staff C arrived to the dining room with a medication bin for Resident #3.

On . . . . at 9:25 AM, Staff C put gave the medications to the resident while she said at 9:26 AM in

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Spanish "las medicinas que te mando el medico". It meant in Spanish "these are the medications ordered by the doctor." The resident took her medications by herself and Staff C initialed the MORs. Staff C did not say aloud the name of the medications to the resident.

Review of medication cards for Resident #3 showed that the medications she took were: Sod DR 40 mg tab with an order to take one tablet by in the morning, 150 mg tab with an order to take one tablet by daily as needed with food, Malteate 2.5 mg tab with an order to take one tablet by daily, 120 mg tab with an order to take one tablet by daily, 40 mg cap with an order to take one capsule by daily, 300 mg cap with an order to take one capsule by twice a day, D3 50 mcg (2000 IU) take one tablet daily and 5 mg tab take half a tablet by twice a day. All the medications that Resident #3 took on the morning of at 9:26 AM were scheduled at 6 AM.

3. On at 9:50 AM, Staff C, followed the same procedures with Resident #2 that she had with Residents #3 and #5. Staff C gave the medications to the resident and just said in Spanish "las medicinas que te mando el medico". It meant in Spanish "these are the medications ordered by the doctor." The resident took her medications by herself and Staff C initialed the MORs. Staff C did not say aloud the name of the medication to the resident.

Review of medications' cards for Resident #2 showed that the medications she took were: Sod DR 40 mg tab with order to take one tablet by daily, DR 30 mg cap with order to take one capsule by daily, 325 mg tab with order to take one tablet by daily, 10 mg tab with order to take one tablet by daily, Multiviatmins one daily with order to take one tablet by daily, 112 mcg take one tablet daily, 2.5 mg tab take one tablet by daily. All the medications that Resident #2 took on the morning of at 9:50 AM were scheduled at 6 AM.

On at 12:48 PM, Staff C revealed that she did not wash her because she wore gloves during the med pass. She further stated she was told that the staff did not have to read the medications to the residents.

Class III

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

Based on observation, record review and interview, the Assisted Living Facility failed to ensure that Medication Observation Records (MORs) included the directions for use of each medication and that the

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medications had a scheduled time for two out of nine sampled residents (#1 and #5).

Findings included:

Review of Resident #1's MORs showed that there was a doctor's order for Celecoxir 200 mg caps. It did not have a specific scheduled time, stating only "AM" and "PM".

Review of Resident #5's MORs showed that there was a doctor order's for , Refiet , Wash. It did not have instructions regarding the directions for use of the medication and the scheduled time for taking the medication. , Refiet , Wash was scheduled "AM" and "PM.

On at 3:12 PM, the Administrator revealed that he would contact the pharmacy to fix the problems with the MORs.

Class III

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

Based on record review and interview, the Assisted Living Facility failed to contact the health care provider to obtain revised instructions for the medications ordered for use 'as needed' for two out of nine sampled residents (#1, #2, and #3).

Findings included:

Review of Resident #1's MORs showed that there was a doctor order for Celecoxir 200 mg caps. It showed on the instructions to take one capsule by twice a day with food as needed.

Review of Resident #2's MORs showed that there was a doctor's order for HFA 90 mcg to inhale 2 puffs every 8 hours for . There was no documentation about the reasons for not receiving during the whole day on and in the morning dose on . The schedule time for the medication did not follow the doctor order of every 8 hours. Medication scheduled time was 6 AM, 2 PM and 6 PM.

On at 9:25 AM, Staff C assisted Resident #3 with self-administration of medication. Staff C put the medications in a small disposable and gave them to the resident while she said at 9:26 AM in Spanish "las medicinas que te mando el medico". It meant in Spanish "these are the medications ordered by the doctor." The resident took her medications by herself and Staff C initialed the MORs.

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Staff C did not say aloud the name of the medication to the resident.

Review of medication cards for Resident #3 showed that the medications she took included 150 mg tab with order to take one tablet by daily as needed with food. Staff initialed 150 mg tablet on and ; there was no documentation about the circumstances under which 150 mg tab would be appropriate for the resident to request the medication and any limitations must be specified.

On at 3:15 PM, the Administrator revealed that none of the facility's staff were licensed staff. She further stated that someone told the facility that those doctor orders did not have any problems for an ALF. Resident #2 did not take the medication ( ) because she took it only when she had . She did not need it every day, every eight hours.

Class III

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

Based on observation, record review and interview, the Assisted Living Facility did not have a staffing pattern that showed the staff work hours.

Findings inlcuded:

On at 8:04 AM, Staff B and C were on duty in the facility with six residents and one day care participant. Staff B toured that facility while Staff C was in the facility in the kitchen.

On at 8:07 AM, there was a man in the facility's office and identified himself as Staff D. He revealed that he was on duty at that time due to he worked the previous night shift.

Review of staffing calendar showed that there was no time set for the staff. Staff B worked as a live-in staff from Monday to Friday. Staff C worked as live in Sunday, Monday, Tuesday, and Saturday. Staff D worked as live in Sunday, Wednesday, Thursday, Friday, and Saturday.

On at 12:45 PM, Staff C revealed that she worked as a live-in staff on Saturday, Sunday, Monday and Tuesday from 5 AM to 8PM or 9 PM.

On at 1:30 PM, Staff B revealed that she worked as a live-in staff Monday thru Friday from 5 AM to 8PM or 9 PM.

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On at 1:53 PM, Staff D revealed that he worked as a live-in staff on Saturday, Sunday, Wednesday, and Thursday from 5 AM to 8PM or 9 PM.

On at 3:15 PM, the Administrator revealed that she did not know that the facility needed to show in the schedule the hours.

Class III

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

Based on record review and interview, the Assisted Living Facility failed to ensure that the admission and discharge log included the home address to which the resident was discharged for two out of nine sampled residents (#7 and #8).

Findings included:

Review of the admission and discharge log showed that Resident #7's discharge date was on by 'family choice' and the discharge place showed 'N/A with husband'. Resident #8's discharge date was on by family choice and the discharge place showed 'daughter's house'.

On at 3:17 PM, the Administrator revealed that the facility did not acknowledge that the home address to which the resident was discharged needed to have to be documented in the admission and discharge log.

Class III