STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965734	**04/30/2019**
NAME OF PROVIDER OR SUPPLIER **MARY'S HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **14158 NW 88 PLACE** **HIALEAH, FL 33018**	

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

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 2 background screening completed for one out of five (Staff E) sampled staff prior to being left alone with residents.

Findings included:

On . . . . at 6:00 AM observations found Staff E in the facility alone with a census of eight residents. Staff E revealed she had been working in the facility for two days.

A search on . . of the background screening database found Staff E was not listed on the employee roster. A search on . . . . of Staff E's background in database found she did not have a screening completed. Background screening database found no matches for Staff E found.

On at 8:03 AM the Administrator stated, "She has no file. She was covering for my daughter (Staff C)."

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 eight residents. The facility provided services to residents outside the current license capacity of six.

Findings included:

Observation on . . . . at 6:00 am found Staff E alone with eight residents despite being licensed for six beds. Further observations on at 6:05 am found Resident # 6 sleeping in # , Resident #2 and Resident #1 in . . # . Next, Resident #4 in . . # with Resident #5. Resident #8 was sleeping in # 's closet. Then, Staff D and E stated that Resident #7 slept on the recliner due to she likes to sleep there, where Resident #7 had two pillows and a sheet. Further observations found Resident #3 was sleeping in the room next to the living room, which was also the facility's office. Resident #3's bed have three chairs against the bed.

Interview on . . . . at 6:00 am Staff E stated that she put the chairs against Resident #3' bed to

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prevent her from falling.

The admission/discharge log reflected Resident #7 was admitted on and Resident #8 was admitted on as daycare clients. Resident #8's contract reflected dropped at 7:00 am and picked up at 7:00 pm. Resident #7's contract reflected dropped at 7:00 am and picked up at 7:00 pm.

Interview on at 6:05 am Staff D and E stated that the facility provided medications to all residents including Residents #7 and #8.

Observation on at 6:05 am revealed a locked cabinet at the laundry area with Residents #7 and #8's medications. Furthermore, Residents #7 and #8's medications observation records (MOR) were in blank. In addition, the MOR reflected that Resident #7 had 100/mg twice a day.

Interview on at 6:30 am Staff D and E revealed that they provided assistance to the Residents received with the daily living activities (ADLs). Observation on at 7:00 am revealed Staff E assisting Resident #8 in the room/closet by herself.

Interview on at 9:04 am, Staff A stated, Resident #7 never got used to sleep on a bed, and she liked to sleep on the recliner. When she stayed here, she slept on the recliner.

Resident #7's medications:
The morning medications were 200 mg, , Desylate 10 mg, ,
, 20 mg CPDR, , 1 mg and , 5 MG
Afternoon medications were , 5 mg and 10 mg
Evening medications was , 100 mg
Bedtime medications was ER 28 mg

Resident #8's medications:
The morning medication was , 20 mg and Constulose 10 mg
Bedtime medication was , 25 mg

Unclassified

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

0000 - Initial Comments

A biennial survey was conducted at Mary's Home Inc. on and concluded on . Deficiencies were identified at 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 used chairs as to one of eight (# 3) sampled residents' beds.

Findings included:

Observation on at 6:00 am revealed Resident #3 was sleeping in the room next to the living room, which was also the facility's office. This room also has a glass door wall, and Resident #3's bed have three chairs against the bed.

Interview on at 6:00 am Staff E stated that she put the chairs against Resident #3's bed to prevent her from falling.

Class III

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

Based on record review and interview the facility failed to maintain a daily medication observation record (MOR) for eight of eight sampled residents (#s).

Findings included:

Record review revealed the MORs for Residents #4, #6, #7 and #8 were blank. Record review revealed the MORs had a letter "M" initialed for the morning medications for Residents #1, #2, #3 and #5. However, the facility did not have any current staff members with the initial "M" in the facility during the medication pass.

Interview on at 10:00 am Staff A stated Residents #4 and #6 have a HMO insurance, and she did not have time to fill the MOR sheets.

Interview at 11:03 am Staff A confirmed, "I signed the MOR previously daily because I do not trust

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

staffing, I do not want to lose track on my MOR."

Class III

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

Based on observation and interview the facility failed to ensure that medications in a locked compartment for one out eights (#7) sampled residents.

Findings included:

On at 6:10 AM during the tour the right refrigerator door was found with wrapped in a wash cloth and stuff in a cracker box for Resident #7.

On at 1:30 PM the Administrator acknowledged the was not locked and stated that the daughter bought it last night.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on observations, record review, and interview the facility failed to ensure that qualified staff performed their assigned duties consistent with their level of education, training, preparation, and experience for one of five sampled staff (Staff E). Staff E was left alone with eight residents without having an eligible level 2 background screening. The facility failed to provide verification of First Aid and ( ) training, or any other training documentation. The facility also failed to ensure that all staff exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider for one of sight sampled residents (Resident #7). Resident #7 was ordered to receive but the facility failed to coordinate the services or following with the resident's health care provider. The facility failed to provide evidence of a negative examination documented on an annual basis for two of four sampled staff (Staff B and C).

Findings included:

On at 6:00 AM observed Staff E alone in the facility with a census of eight residents: Resident #1 was admitted to hospice on with Resident#2's health assessment dated had diagnoses of ( ),

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

, , , , , , nephrolothiasis, lower , , , , .
She required assistance with all activities of daily living.
Resident #3's health assessment dated had diagnoses of mental , and partial , , , . She needed assistance with supervision with all activities of daily living.
Resident #4's health assessment dated had had diagnoses of gait instability, , , insufficiency, , , hearing loss. She required assistance with ambulation, bathing, , grooming, toileting and transferring. She needs supervision with eating.
Record review of Resident #5's health assessment dated had diagnoses of mental , partial , , , airway obstruction. She required assistance with all activities of daily living.
Resident #6's health assessment dated had diagnoses of , dyslipidemia, , , , , . She required total assistance with all of her activities of daily living.
Resident #7's health assessment dated had diagnoses of type 2, III (, ,), , , , . She needed supervision with her activities of daily living.
Resident #8's health assessment dated had diadnoses of , , , abnormal , , , , , , . She needed supervision with her activities of daily living. Staff E revealed she had been working in the facility for two days. She was observed assisting residents with morning care.

Further observations on at 6:05 am found Resident # 6 sleeping in #., Resident #2 and Resident #1 in # . Next, Resident #4 in # with Resident #5. Resident #8 was sleeping in # 's closet. Then, Staff D and E stated that Resident #7 slept on the recliner because she likes to sleep there. Resident #7 had two pillows and a sheet. Further observations found Resident #3 was sleeping in the room next to the living room, which was also the facility's office. Resident #3's bed had three chairs against the bed.

Personnel record review found there were no records for Staff E. The facility did not have evidence of an eligible level 2 background screening, First Aid or training, or any other training documentation for Staff E prior to leaving her alone with the residents. Observations found on at 6:10 AM Staff D arrived.

On at 8:03 AM the Administrator stated, "Staff E has no file. On at 1:30 PM the Administrator acknowledged Staff E did not have the file with and First Aid training or any other training documentation.

On at 7:12 AM observed Staff A (administrator) remove two cups with pre-poured medications for Residents #4 and #7. Staff A walked into # and handed Staff E the cup with medications for

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Resident #4. Staff E observed assisting Resident #4 with medication and then assisted Resident #4 to the bathroom for a bath.

Review of the medication observation records revealed they had been initialed prior to the medications being given to residents. On at 11:30 AM the Administrator acknowledged it was not the proper way to assist with the medications.

2) Observation on at 6:07 am revealed the facility had for Resident #7 inside of the refrigerator in an empty cracker box covered with a cloth. Attempted an interview with Resident #7 but the resident unable to respond.

Medication observation records documented 100 unit/ml to inject 15 units at morning and 30 units at bedtime. Resident #7's assessment documented moderate with short-term memory loss and disoriented. Resident #7 needed assistance with self-administration of medication and signed a consent for unlicensed personnel to assist her with self-administration of medications.

The facility did not have any written information indicating that a home health nurse was administering the twice a day to Resident #7. Resident #7's progress notes did not indicate how Resident #7 was receiving the and did not have the levels documented.

On at 6:05 am Staff D and E stated that the facility provided medications to all residents including Residents #7 and #8.

Personnel record review found Staff D and E were not licensed personnel.

On at 11:40 am Staff A stated, "Resident #7 administered her two times a day. Resident #7 did not have a daily level log because her daughter refused it; Resident #7 got nervous with that.

Based on survey findings the Department of Children and Families were contacted to evaluate Resident #7.

3) Record review revealed that Staff B, C and D's records showed expired statements of freedom from ( ):

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SUMMARY STATEMENT OF DEFICIENCIES
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Staff B (hired) had a exam issued
Staff C (hired) had a exam issued

On at 1:00 pm Staff A stated, "Staff B and C needed to update their exams."

Class II

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

Based on observation, 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:

Observation on at 9:00 am revealed that the facility had eight residents and one staff member.

Record review revealed that the facility had a staffing pattern from - . The staffing pattern reflected two staffs from 7:00 am - 6:00 pm.

Interview on at 11:00 am Staff A stated, "I will have two staff at all times."

Class III

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

Based on observation and interview, the facility failed to ensure that the property was maintained.

Findings included:

On at 6:25 AM AM found peeling paint on the ceiling wall at the entrance area of the living of the facility and a light bulb no working in the refrigerator.

On AM at 1:30 PM the Administrator confirmed the ceiling was peeling and the light was out in the refrigerator.

Class III

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SUMMARY STATEMENT OF DEFICIENCIES
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0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on observations, record review and interview the facility failed to personnel records available onsite for one out of five (Staff E) sampled staff.

Findings included:

On at 6:00 AM observations found Staff E in the facility alone with a census of eight residents. Staff E revealed she had been working in the facility for two days.

Personnel records revealed the facility did not have a record for Staff E. The facility did not have a completed application or training documentation.

Class III

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

Based on record review and interview the facility failed to have a completed health assessment for one of eight sampled residents (Resident #6).

Findings included:

Record review revealed the facility did not have a completed health assessment for Resident #6. The health assessment dated did not have Resident #6's diagnosis information.

Interview on at 1:00 pm Staff A confirmed Resident #6's health assessment was missing the diagnosis information.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation and interview, the facility failed to be in compliance with the emergency environmental control requirements.

Findings included:

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Observations on at 9:30 am revealed the facility did not have a monoxide detector installed. In addition, the facility had the gasoline gallons in storage; however, they were empty.

Record review revealed that the facility's emergency power plan (EPP) stated that the facility would have monoxide of monoxide detector installed and fuel for the generator.

The facility did not have a signed document from residents or family members acknowledging the implementation of the EPP. In addition, the facility did not have documentation to proof that the staffs received an in-service regarding the EPP.

Interview on at 10:00 am, Staff A confirmed that the facility needed to install the monoxide of detector. Staff A acknowledged that the facility did not provide documentation to the residents or family members regarding the implementation of the EPP. In addition, Staff A stated, "I explained staff about the EPP, but I do not have any documentation in writing."

Class III

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

0000 - Initial Comments

A biennial survey was conducted at Mary's Home Inc. on and concluded on . Deficiencies were identified at 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 used chairs as to one of eight (# 3) sampled residents' beds.

Findings included:

Observation on at 6:00 am revealed Resident #3 was sleeping in the room next to the living room, which was also the facility's office. This room also has a glass door wall, and Resident #3's bed have three chairs against the bed.

Interview on at 6:00 am Staff E stated that she put the chairs against Resident #3's bed to prevent her from falling.

Class III

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

Based on record review and interview the facility failed to maintain a daily medication observation record (MOR) for eight of eight sampled residents (#s).

Findings included:

Record review revealed the MORs for Residents #4, #6, #7 and #8 were blank. Record review revealed the MORs had a letter "M" initialed for the morning medications for Residents #1, #2, #3 and #5. However, the facility did not have any current staff members with the initial "M" in the facility during the medication pass.

Interview on at 10:00 am Staff A stated Residents #4 and #6 have a HMO insurance, and she did not have time to fill the MOR sheets.

Interview at 11:03 am Staff A confirmed, "I signed the MOR previously daily because I do not trust

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staffing, I do not want to lose track on my MOR."

Class III

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

Based on observation and interview the facility failed to ensure that medications in a locked compartment for one out eights (#7) sampled residents.

Findings included:

On at 6:10 AM during the tour the right refrigerator door was found with wrapped in a wash cloth and stuff in a cracker box for Resident #7.

On at 1:30 PM the Administrator acknowledged the was not locked and stated that the daughter bought it last night.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on observations, record review, and interview the facility failed to ensure that qualified staff performed their assigned duties consistent with their level of education, training, preparation, and experience for one of five sampled staff (Staff E). Staff E was left alone with eight residents without having an eligible level 2 background screening. The facility failed to provide verification of First Aid and ( ) training, or any other training documentation. The facility also failed to ensure that all staff exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider for one of sight sampled residents (Resident #7). Resident #7 was ordered to receive but the facility failed to coordinate the services or following with the resident's health care provider. The facility failed to provide evidence of a negative examination documented on an annual basis for two of four sampled staff (Staff B and C).

Findings included:

On at 6:00 AM observed Staff E alone in the facility with a census of eight residents: Resident #1 was admitted to hospice on with Resident#2's health assessment dated had diagnoses of ( ),

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

, , , , , , nephrolothiasis, lower , , , , .
She required assistance with all activities of daily living.
Resident #3's health assessment dated had diagnoses of mental , and partial , , , . She needed assistance with supervision with all activities of daily living.
Resident #4's health assessment dated had had diagnoses of gait instability, , , insufficiency, , , hearing loss. She required assistance with ambulation, bathing, , grooming, toileting and transferring. She needs supervision with eating.
Record review of Resident #5's health assessment dated had diagnoses of mental , partial , , , airway obstruction. She required assistance with all activities of daily living.
Resident #6's health assessment dated had diagnoses of , dyslipidemia, , , , , . She required total assistance with all of her activities of daily living.
Resident #7's health assessment dated had diagnoses of type 2, III (, ,), , , , . She needed supervision with her activities of daily living.
Resident #8's health assessment dated had diadnoses of , , , abnormal , , , , , , . She needed supervision with her activities of daily living. Staff E revealed she had been working in the facility for two days. She was observed assisting residents with morning care.

Further observations on at 6:05 am found Resident # 6 sleeping in #., Resident #2 and Resident #1 in # . Next, Resident #4 in # with Resident #5. Resident #8 was sleeping in # 's closet. Then, Staff D and E stated that Resident #7 slept on the recliner because she likes to sleep there. Resident #7 had two pillows and a sheet. Further observations found Resident #3 was sleeping in the room next to the living room, which was also the facility's office. Resident #3's bed had three chairs against the bed.

Personnel record review found there were no records for Staff E. The facility did not have evidence of an eligible level 2 background screening, First Aid or training, or any other training documentation for Staff E prior to leaving her alone with the residents. Observations found on at 6:10 AM Staff D arrived.

On at 8:03 AM the Administrator stated, "Staff E has no file. On at 1:30 PM the Administrator acknowledged Staff E did not have the file with and First Aid training or any other training documentation.

On at 7:12 AM observed Staff A (administrator) remove two cups with pre-poured medications for Residents #4 and #7. Staff A walked into # and handed Staff E the cup with medications for

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

Resident #4. Staff E observed assisting Resident #4 with medication and then assisted Resident #4 to the bathroom for a bath.

Review of the medication observation records revealed they had been initialed prior to the medications being given to residents. On at 11:30 AM the Administrator acknowledged it was not the proper way to assist with the medications.

2) Observation on at 6:07 am revealed the facility had for Resident #7 inside of the refrigerator in an empty cracker box covered with a cloth. Attempted an interview with Resident #7 but the resident unable to respond.

Medication observation records documented 100 unit/ml to inject 15 units at morning and 30 units at bedtime. Resident #7's assessment documented moderate with short-term memory loss and disoriented. Resident #7 needed assistance with self-administration of medication and signed a consent for unlicensed personnel to assist her with self-administration of medications.

The facility did not have any written information indicating that a home health nurse was administering the twice a day to Resident #7. Resident #7's progress notes did not indicate how Resident #7 was receiving the and did not have the levels documented.

On at 6:05 am Staff D and E stated that the facility provided medications to all residents including Residents #7 and #8.

Personnel record review found Staff D and E were not licensed personnel.

On at 11:40 am Staff A stated, "Resident #7 administered her two times a day. Resident #7 did not have a daily level log because her daughter refused it; Resident #7 got nervous with that.

Based on survey findings the Department of Children and Families were contacted to evaluate Resident #7.

3) Record review revealed that Staff B, C and D's records showed expired statements of freedom from ( ):

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SUMMARY STATEMENT OF DEFICIENCIES
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Staff B (hired) had a exam issued
Staff C (hired) had a exam issued

On at 1:00 pm Staff A stated, "Staff B and C needed to update their exams."

Class II

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

Based on observation, 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:

Observation on at 9:00 am revealed that the facility had eight residents and one staff member.

Record review revealed that the facility had a staffing pattern from - . The staffing pattern reflected two staffs from 7:00 am - 6:00 pm.

Interview on at 11:00 am Staff A stated, "I will have two staff at all times."

Class III

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

Based on observation and interview, the facility failed to ensure that the property was maintained.

Findings included:

On at 6:25 AM AM found peeling paint on the ceiling wall at the entrance area of the living of the facility and a light bulb no working in the refrigerator.

On AM at 1:30 PM the Administrator confirmed the ceiling was peeling and the light was out in the refrigerator.

Class III

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0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on observations, record review and interview the facility failed to personnel records available onsite for one out of five (Staff E) sampled staff.

Findings included:

On at 6:00 AM observations found Staff E in the facility alone with a census of eight residents. Staff E revealed she had been working in the facility for two days.

Personnel records revealed the facility did not have a record for Staff E. The facility did not have a completed application or training documentation.

Class III

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

Based on record review and interview the facility failed to have a completed health assessment for one of eight sampled residents (Resident #6).

Findings included:

Record review revealed the facility did not have a completed health assessment for Resident #6. The health assessment dated did not have Resident #6's diagnosis information.

Interview on at 1:00 pm Staff A confirmed Resident #6's health assessment was missing the diagnosis information.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation and interview, the facility failed to be in compliance with the emergency environmental control requirements.

Findings included:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965734	**04/30/2019**
NAME OF PROVIDER OR SUPPLIER **MARY'S HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **14158 NW 88 PLACE** **HIALEAH, FL 33018**	

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

Observations on at 9:30 am revealed the facility did not have a monoxide detector installed. In addition, the facility had the gasoline gallons in storage; however, they were empty.

Record review revealed that the facility's emergency power plan (EPP) stated that the facility would have monoxide of monoxide detector installed and fuel for the generator.

The facility did not have a signed document from residents or family members acknowledging the implementation of the EPP. In addition, the facility did not have documentation to proof that the staffs received an in-service regarding the EPP.

Interview on at 10:00 am, Staff A confirmed that the facility needed to install the monoxide of detector. Staff A acknowledged that the facility did not provide documentation to the residents or family members regarding the implementation of the EPP. In addition, Staff A stated, "I explained staff about the EPP, but I do not have any documentation in writing."

Class III