Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966999	A. BUILDING: _____ B. WING _____	R 08/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICKY'S HOME ALF	6402 SW 41 STREET MIAMI, FL 33155

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A revisit to a re-licensure survey was conducted at Vicky's Home ALF on . . . . Deficiencies were identified at the time of the survey:	{A 000}		
{A 054} SS=D	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known . . the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical . . , the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication.	{A 054}		

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{A 054}	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have accurate documentation in the Medication Observation Records (MOR) for four out of 13 sampled residents (#10, #12, #7 and #2). The facility failed to ensure that the MOR included the charting period, the name of the resident's primary care physician, and the phone number of the resident's primary care physician one out of 13 sampled residents (#2). Findings included: Review of Resident #10's MOR revealed that there was an order for [redacted] 20 mg to take one capsule by [redacted] once a day in the morning before eating. The order was handwritten and the staff started to initial it on the 6th but stopped on the 15th. His MOR also included an order for taking half tablet of [redacted] 5 mg by [redacted] twice a day. On [redacted] at 9:32 AM, the [redacted] for Resident #10 was reconciled and the bottle of the medication had 22 capsules inside. The bottle showed that the pharmacy dispensed 30 capsule of the medication on [redacted]. There was a half white tablet inside the medication bin. On [redacted] at 9:37 AM, the Staff F revealed that Resident #10 took the [redacted] every time she assisted him with medication. Review of Resident #12's MOR included an order of [redacted] 850 mg tablet for taking one tablet by [redacted] twice a day, an order of [redacted], 5 mg tablet for taking half tablet by [redacted] twice a day, an order of [redacted] 10 mg tablet for taking two tablets by [redacted] twice a day, and an order of [redacted] Mes 1 mg tablet for taking	{A 054}		

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{A 054}	Continued From page 2 one tablet by . . . . twice a day. Those medications were scheduled at 8 AM and 8 PM. The staff did not initial the morning dose of those medications on . . Review of Resident #7's MOR for the charting covering from . . . . . to . . . . . revealed that her morning medications were scheduled at 8 AM. The staff initialed the morning doses on before 8:33 AM. On at 9 AM, the Staff F revealed that Residents #10, #12 and #7 took all their medications. On further interview at 9:03 AM, she added that Resident #7 left the facility approximately at 6:20 AM every day that she goes to the program, the transportation picked her up. Review of Resident #2's MOR revealed that the MORs did not include the charting period, the name of the resident's primary care physician, and the phone number of the resident's primary care physician. There was an order of Etiquis 5 mg tablet for taking one tablet by . . . . twice a day. It was scheduled at 8 AM and 8 PM. The staff signed the 8 PM dose on . . . . . . Uncorrected Class III	{A 054}		