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
	AL11969622	A. BUILDING: _____ B. WING _____	08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALMO 23 III LLC	808 WEST 1 AVENUE HIALEAH, FL 33010

(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 complaint investigation (complaint number 2021007996) was conducted at Salmo 23 III on to . A deficiency was identified at the time of survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule	A 025		

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
	AL11969622	A. BUILDING: _____ B. WING _____	08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALMO 23 III LLC	808 WEST 1 AVENUE HIALEAH, FL 33010

(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 025	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain a general awareness of the resident whereabouts and personal supervision for three out of six sampled residents (Resident #1, #5 and #6). Resident #1 eloped from the facility and was missing for approximately 28 days. Residents #5 was assaulted by another resident which resulted in injury, need of emergency care, and found to have sustained lateral left frontal [redacted], hematoma and small focus of [redacted] left parietal [redacted]. Resident #6 reported to staff he had issues with another resident and received no intervention and eventually led resident to assault another resident.	A 025		

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
	AL11969622	A. BUILDING: _____ B. WING _____	08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALMO 23 III LLC	808 WEST 1 AVENUE HIALEAH, FL 33010

(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 025	Continued From page 2 Findings included: 1) A review of the facility report showed that staff could not locate resident #1 and who was last seen in the facility on . A review of Resident #1's record showed he was admitted to the facility on . The health assessment completed on showed that the resident had diagnoses of , and . The section stated that staff is to report any changes as they occur based on daily observation. The resident is independent with ambulation, eating and toileting, bathing, , grooming, and transferring, and need assistance with self-administration of medication. The health assessment documented that the resident was not identified as an elopement risk at the time of admission. A review of Resident #1's observation note showed 'on Staff E noticed during rounds that Resident #1 was not in the facility. After a search of the facility rooms, bathrooms, common areas and patio for the resident the Administrator was contacted and informed about missing resident. The resident did not have a prior history of elopement and present any signs of an elopement. The facility contacted the police department after searching surrounding area outside and resident #1 was not found. Facility was given a police report for missing person and contacted the physician, his case worker.' Further review of the observation note revealed, 'Resident #1 had an open case with Department of Children and Families (DCF) due to a removal from his house and he is undergoing a court order from DCF to have a legal guardian	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969622	A. BUILDING: _____ B. WING _____	08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALMO 23 III LLC	808 WEST 1 AVENUE HIALEAH, FL 33010

(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 025	Continued From page 3 appointed.' On [redacted] at 9:30 am the Administrator stated, "Resident #1 wanted to go to his house, and he expressed that he passed the time out walking at a friend's house. Resident is oriented, he knew where to go and how, he also knew how to return to facility by himself. On Resident #1 came [redacted] to facility by himself. He arrived in good condition only saying he had [redacted], because he walked too much. I called the doctor, who recommended to send him to the hospital for evaluation. He returned to facility from the hospital on [redacted]. Resident #1 was assessed as at risk for elopement, and a new health assessment was completed. I completed another drill after resident eloped. Staff was retrained on elopement. Daily rounds are conducted to check on residents.' A Review of Resident #1 hospital record showed hospital admission date for [redacted] at 10:00 a.m. Admitting diagnosis included, unspecified [redacted] not due to a substance or known physiological condition. The hospital Social Services notes revealed,' Patient was evaluated at Emergency Room (ER) for an acute [redacted], case manager contacted with assisted living facility Administrator by phone, she was informed patient has criteria for admission for current condition, she stated patient has been sent to the hospital to be evaluated by a psychiatrist consultant after patient was missing from the ALF for about one month and was out of control and without medication. The Case was assigned to a doctor." The [redacted] discharge summary showed, 'Long term history of [redacted] Patient was [redacted] for having flight ideas and keeps trying to escape the nursing home. Patient during interview is [redacted], restless, hyper verbal,	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969622	A. BUILDING: _____ B. WING _____	08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALMO 23 III LLC	808 WEST 1 AVENUE HIALEAH, FL 33010

(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 025	Continued From page 4 .. Patient denies . . . . . / . . . . . . Denies . Chief Complaint: "I feel . . . . . ." Admitting Diagnosis: . . . . . R/O . . in acute exacerbation.' On . . . . at 11:50 AM Staff B stated, she was familiar with Resident #1 routine. Staff B stated on . . . . . , "He was sitting on a bench by his room like he always does. I called him for dinner since he likes to eat early. He sat in the dining area and had his dinner; he then went outside. When I went to get other residents to guide them to the dining room, I noticed he wasn't sitting on the bench where he usually sits after dinner to smoke a cigarette. I immediately started calling him by his name and searched around the facility. He likes to read his book while sitting on his favorite bench and observe around while smoking his cigarettes. When I didn't see him, I panicked, and called everyone to help me look for him. That was around 5:10 p.m., I believe. I don't know why he did that. Resident #1 was gone for a long time. We reviewed the cameras and we saw him jumped the fence in the . . . . of the facility. He had a bracelet on with his ID. He must have taken it off because when he got . . . to the facility, he did not have it on." On at 9:40 AM Resident #1 stated he decided to go out of the facility. He stated the staff did not want him to go out of the facility and he could not understand why. He stated, "I am not a convict, not a robber, and had not killed anybody. He stated he felt like he was in jail, and he only wanted to take a walk, which is something he always did. He stated, I was out for days. I walked to a friend's house to bathe. I had money to buy food. I moved from one place to the another and used my bus pass to ride the public	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969622	A. BUILDING: _____ B. WING _____	08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALMO 23 III LLC	808 WEST 1 AVENUE HIALEAH, FL 33010

(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 025	Continued From page 5 transportation. I came . . . after a few days by myself." On 0/ at 12:50pm a telephone interview was conducted with Resident #1 case manager, he stated," the resident was living at home prior to admission to the facility. He did not elope before. He was found in his home under inappropriate living conditions and placed in the assisted living facility temporarily. The facility was informed that the resident was placed in the assisted living to receive living accommodations, medications, and meals. The facility was informed to provide extra supervision because the resident had a "court case" and in the process of having a court appointed guardian, however he was not prohibited from leaving the facility. Three separate assessments were conducted by the doctors, appointed by the court, to determine if the resident qualified for guardianship program, not for the appropriateness of an ALF admission." A review of the facility's policies and procedures dated revealed, 'any residents being placed by the Department, or the Department of Children and Families shall have been examined by medical personnel within 30 days before placement in the facility. The examination shall include an assessment of appropriateness of placement in the facility. The findings of this examination shall be recorded on the examination form provided by the facility. The completed form shall accompany the resident and shall be submitted to the facility owner or administrator. A review of Resident #1 record found there was no assessment by medical personnel to determine appropriateness of placement within 30 days prior to placement at the facility. 2) A review of Resident #5's record showed she	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969622	A. BUILDING: _____ B. WING _____	08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALMO 23 III LLC	808 WEST 1 AVENUE HIALEAH, FL 33010

(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 025	Continued From page 6 was admitted to the facility on . The health assessment completed on showed that the resident had diagnoses of , , , , ( ), . The section stated that staff is to report any changes as they occur based on daily observation. The resident was independent with ambulation, eating, transferring and needs assistance with bathing, , grooming and toileting, and needed assistance with self-administration of medication. A review of Resident #5's progress note showed on ' Resident #5 got in an argument with Resident #6. Resident #5 reported to staff that resident #6 pushed her to the ground and had kicked her during the argument. Resident #5 reported to have a and started to . The supervisor immediately called the doctor and asked that she be sent to hospital to be evaluated. The ambulance was called, and resident was transferred to hospital. The resident's daughter was notified of the incident and the hospitalization. ' A review of Resident #5 hospital record showed she was admitted to the hospital on with a diagnosis of "lateral left frontal , hematoma and small focus of left parietal . The , female with past medical history (PMH) and , ( ) presenting as a transfer from hospital where she was found to have a reports the patient had an altercation with another resident at assisted living facility several hours ago and subsequently got ." On at 9:40 AM the Administrator stated,	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969622	A. BUILDING: _____ B. WING _____	08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALMO 23 III LLC	808 WEST 1 AVENUE HIALEAH, FL 33010

(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 025	Continued From page 7 "Residents #5 and #6 had a fight due to Resident #5 believed every man was her husband or her son and treated them as such. After the fight resident # 5 was sent to hospital for evaluation and resident #6 requested to be transferred to our sister facility where he is at this present time. " On at 11:29 AM Staff C stated "Resident #5 was walking through the hallways of the male's aisle when she screamed at Resident #6 and screamed again. Resident #6 was a nice guy, quiet. I don't know what happened. Resident #6 just went to Resident #5 quick, running towards her and kicked her on her . Resident #6 is tall and was able to hurt her. Resident #5 on her butt. She was sent to the hospital immediately to evaluate her. Resident #5 had problems with him before, like bugging him, but she is not aggressive at all, she is a very nice lady." On at 11:38 AM Staff E stated, Staff G called me by radio and said resident #5 had . after Resident #6 kicked her. Resident #5 had sustained an injury to her . . . . I asked Resident #6 what happened, and he said, Resident #5 was bothering him. Resident #5 used to look for him to sit on his , and give him kisses. I am guessing she was . . . . due to her mental status and maybe thought he was her husband or son. We had to be on her constantly. We then directed her to another place." A review of Resident #5 record found staff had prior knowledge of Resident # 5 and #6 conflicts, that eventually led to Resident #5 to be assaulted by Resident #6. There was no documentation Resident #5 received care and services related to her and mental state, "believing every man was her husband and treated as such, sitting	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969622	A. BUILDING: _____ B. WING _____	08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALMO 23 III LLC	808 WEST 1 AVENUE HIALEAH, FL 33010

(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 025	Continued From page 8 on Resident #6 , , and giving kisses, and having a problem with Resident #6." at 9.30 AM, The Administrator stated, "it was an fight. They always tried to match roommates with similar interests. When they observe any resident or acting different, they call the psychiatrist and the doctor for evaluation and if required send the resident to the hospital. After the fight they have more staff present all time in the common areas and patio to prevent similar situation. Resident #5 is closely supervised. Residents are under constant supervision by the doctors and staff." A review of Resident #6's record showed he was admitted on . The health assessment completed on showed that the resident had diagnoses included (CVD) , and . The section stated that staff is to report any changes as they occur based on daily observation. The resident was independent with ambulation, grooming and transferring and needs assistance with bathing, , grooming and toileting, and needed assistance with self-administration of medication. The health assessment documented that the resident was not identified as an elopement risk at the time of admission. A review of Resident #6's progress note showed on , 'Resident #6 had an argument with Resident #5. He pushed resident #5 causing her to on the floor. Resident #6 reported that Resident #5 had insulted and provoked him to fight. Resident #6 was taken to his bedroom by the Staff E where she tried to calm resident down who was very upset and from the argument. Resident #6's psychiatrist was called,	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969622	A. BUILDING: _____ B. WING _____	08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALMO 23 III LLC	808 WEST 1 AVENUE HIALEAH, FL 33010

(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 025	Continued From page 9 and the doctor requested the resident be transferred to hospital to be evaluated. Resident #6 was transferred to the hospital and his son was notified of the incident and the hospitalization.' A review of Resident #6 hospital record showed he was to the hospital on . The Present Illness documented "Patient from assisted living facility due to acute exacerbation of symptoms. A review of Resident #6 record found staff had prior knowledge of Resident # 6 having issues with Resident #5, that eventually led to Resident #6 assaulting Resident #5. There was no documentation the staff put interventions in place to address resident complaint of being bothered by Resident #5. Class II	A 025		