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
	AL11967037	A. BUILDING: _____ B. WING _____	03/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDEZ SENIOR CARE INC	5301 SW 162 PLACE MIAMI, FL 33185

(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 standard biennial survey was conducted at Bermudez Senior Care Inc. on . . . . . The provider had a deficiency identified at the time of the survey.	A 000		
A 033 SS=D	59A-36.007(8) PHYSICAL . . . (8) PHYSICAL . . . . . Residents for whom a physician has prescribed a physical . . . . . must have a written care plan for the use of the physical . . . . The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use; 2. The maximum amount of time the resident is to have the applied each day; and, 3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , , or decline in mobility or function related to the use of the prescribed . (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical . . . . . annually, and documentation of this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical . . . . . and all requirements of this subsection apply. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to have a care plan for the use of full side rails for one out of seven sampled residents (# 5).	A 033		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 033	Continued From page 1 Findings included: During tour of the facility on at 8:28 AM observed that the bed belonging to Resident # 5 had full side rails attached. A record review revealed that the Resident # 5's care plan for the use of dated , had half bed rails written on it. On at 11:10 AM the Administrator stated, "We must do a care plan for full bed rails." Class III	A 033		