STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967448	08/21/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Chanel Nursing Care Alf, Corp	14111 Sw 43 Street Miami, FL 33175	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= J
St - A - 0076 - 58a-5.0186 Fac - ( ) S-S= D

Specific Tag Findings:

0000-Initial Comments

A complaint (CCR# 2014007629) survey was conducted on thu . Chanel Nursing Care Alf, Corp had deficiencies at the time of the survey.

0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on interview and record review, the Assisted Living Facility failed to provide appropriate supervision to meet the needs for one out of five sampled residents (Resident #2). As evidenced by resident #5 being found hanging in the facility's . The facility failed to follow their policy of conducting hourly checks to ensure the safety of all residents.

The Findings included:

Record review of the facility's adverse incident report (dated) documented resident #2 was found by facility staff in the , hanging from an electrical cord attached to a grab bar in the bathtub.

In an interview with the administrator on at 1:00 p.m. she reported, she told the staff to check on the residents every two hours during the night, but she was unable to provide documentation of staff checking residents every two hours.

In an interview with caregiver-A on at 10:16 a.m., she stated the hallway two doors, one to open the one that opens to the toilet and shower. On she woke up between 2 a.m. and 3 a.m. to go the . When she opened the first door in the , she saw that the door of the toilet area was almost closed and the light was on. Resident #2's walker was in front of the sink, therefore she assumed that the being used and she left the to the other # , then she went back to bed. She woke up again between 6 a.m. and 6:30 a.m., she reported, she did not remember the exact time. She reported, when she was coming out of her -B was coming out of the other , in # . She asked caregiver-B, why she was using the other . Caregiver-B told her that resident #2 was using the . Caregiver-A used the other .
While she was in the other -B screamed, "[Caregiver-A's name, caregiver-A name] corre corre mira lo que hizo resident #2" (Translated - caregiver-A name, caregiver-A name, run run look to what resident #2 did). She asked her, what happened and she told her that he hanged himself and told her to call 911 because she did not want to see him. Caregiver-B called 911 and she went to the saw him sitting in the bathtub and hanging. Caregiver-B stayed in the him and spoke with the 911 while Caregiver-A went back to her change her clothes. Caregiver-A reported, resident #2 never told her of any intention of killing or harming himself.

In an interview with caregiver-B on at 10:35 a.m. revealed, when she woke up on about 6 a.m., she reported, she did not remember the exact time. She reported, she usually uses the # . As she was going to # , she saw that the the hallway had the main door almost

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closed, but she could see resident #2's walker. The inner door was closed, so she went to # 's . When she was coming out of # , she saw caregiver-A going to the hallway . She told caregiver-A that resident #2 was using the , and she needed to use the # .

She realized resident #2 was taking too long in the went to check on him. She knocked on the door, and resident #2 did not answer. She knocked again and he did not answer. Then she found him sitting in the bathtub hung with the electrical cord for the electric razor. She panicked and started screaming to caregiver-A. She stepped out and went for the telephone to call 911. While calling 911, she checked on him and called him by his name several times. She placed herself in front of him and saw he had his tongue out and it was black. She followed the 911 operator instructions. While she was on the call with 911, the police arrived. She did not receive any order to provide ( ). The 911 operator told her to cut the cord and when she got the scissors she realized that it was an electric cable. When she informed the operator that it was an electric cable, the operator told her to "do not cut it."

Interviews with caregivers-A and B on at 12:42 p.m. revealed, they were not informed that they had to make rounds to check on residents every hour or every two hours.

Phone interview with resident #2's primary physician on at 12:42 p.m. revealed, he completed resident #2's health assessment. The physician reported, resident #2 needed assistance just for bathing, and supervision with ambulation, dressing, eating, , toileting, and transferring.

Resident record review documented resident #2's health assessment (AHCA form 1823) indicated that he needed assistance with bathing and supervision with ambulation, dressing, eating, , toileting and transferring. The last progress note for resident #2 was dated and documented, "Resident woke up at night around 3:00 am in the hallway of the middle slipped at the entrance of the . Caregiver helped him and called 911 to check on him and help him get up. He did not have any injury. MD [Medical Doctor] and family were notified". There was no progress note or documentation on record of resident #2's alleged on .

Facility record review of staff/aide work schedules documented that from 11 p.m. to 7 a.m. staff members are required to conduct hourly rounds and bed checks to assure the comfort and safety of all residents. And assist any residents that require help.

Record review of the facility's record showed that there was no documentation of staff checking residents every two hours.

Class I

0076- ( ) 58A-5.0186 FAC

Based on record review and interview, the Assisted Living Facility failed to have written policies and procedures for ( ).

The Findings include:

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Facility record review on and on revealed, that there was no written policies and procedures for ( ) in the facility.

During interview with the administrator on at approximately 1:00 p.m. she reported, she did not provide a policy on .

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Chanel Nursing Care Alf, Corp
14111 Sw 43 Street
Miami, FL 33175

RE: CCR #2014007629

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2014 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe.

Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:kb
Enclosure 2014007629
XG90

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