STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968470	08/01/2016
NAME OF PROVIDER OR SUPPLIER **REDLAND ALF INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **20555 SW 187 AVE** **MIAMI, FL 33187**	

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

0000 Initial Comments

Complaint (CCR #2016004597 and 2016006946) surveys was conducted from , 2016 and concluded on , 2016. Redland Alf Inc with Limited Nursing Services and Limited Mental Health components and license number 12377 had the following deficiencies identified at the time of the survey:

0007 Admissions - Criteria

Based on observation, interviews, and record review, the Assisted Living Facility failed to admit a resident who did not meet the admission criteria for one (Resident #5) out of 14 sampled residents.

Findings included:

Observation on / at 9:09 AM revealed that Resident #5 was resting in bed with half-bed rail up. Resident #5 had a

In an interview on at 9:13 AM Caregiver A revealed that Resident #5 cannot move alone.

Review of Resident #5's record revealed that admission date was / . Health assessment (AHCA form 1823) completed on revealed that resident needed total care for all activities of daily living. Resident received hospice services since / with the diagnosis:

In an interview on / at 11:14 AM the Administrator confirmed that Resident was admitted to the facility and two weeks later was admitted to hospice.

Class III

0025 Resident Care - Supervision

Based on observations and interviews, the Assisted Living Facility failed to provide appropriate supervision to one (Resident #5) out of 14 sampled residents. Facility failed to maintain a written record with updated information for one (Resident #14) out of 14 sampled residents.

Findings included:

1. On / at 9:09 AM smelled a strong odor in the hallway where #2, #3 and #4 were. Observation on at 9:09 AM revealed that Resident #5 was resting in bed with half-bed rail up.

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Resident #5 had a ; bag 50 ml of dark yellow , tubing checked and it did not look clog, no cloudiness noted. Observed two medications unlocked in the hospital table next to Resident #5's bed; medicines were: Megestrol AC Sus 40 mg/ml which was labeled for Resident #5 and 262 mg which was not labeled.

In an interview on / at 9:10 AM Caregiver A confirmed that Caregiver A smelled in the hallway and stated " I haven't cleaned yet, we have to take care of many residents." In an interview on / at 9:13 AM Caregiver A revealed that Resident #5 cannot move alone.

Review of Resident #5's record revealed that admission date was / . Health assessment (AHCA form 1823) completed on / revealed that Resident #5 needed total care for all activities of daily living. Resident #5 received hospice services since / . Last interdisciplinary group summery from hospice in record IDG summary on revealed (on healing process) on the sacrum and right hip.

In an interview on / at 11:28 AM Caregiver A revealed that resident had a in the lower back and hospice nurse took care of it every other day, "I am not sure."

In an interview on / / at 12:30 the Administrator revealed that staff members reposition Resident #5 every few hours. Administrator stated "I don't think so" related to having a log that probe that resident was reposition at least every two hours.

2. Review of facility's admission and discharge log revealed that Resident #14 was admitted to the facility on /// and discharge on / . Review of Resident #14's record revealed that progress note completed on revealed that on Resident #14 had and was transferred to Hospital. Family and physician were informed.

In an interview on / at 12:29 PM the Administrator revealed Administrator was not sure if Resident #14 returned from the hospital, Administrator did not remember.

Class III

0030 Resident Care - Rights & Facility Procedures

Based on observations, record review, and interviews, the Assisted Living Facility failed to have a doctor order for the use of a half-bed rail and a signed consent from the resident or legal representative for the use of half-bed rails as well as to treat residents with respect to their privacy for one (Resident #5) out of 14 sampled residents.

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Findings included:

Observation on / at 9:09 AM revealed that Resident #5 was resting in bed with half-bed rail up.

Review of Resident #5's record revealed that resident consent to the use of half-bed rails was not signed by resident/ legal guardian/ responsible party and there was no doctor order for the use of half-bed rail.

In an interview on at 11:06 AM the Administrator revealed that consent was not signed due to resident's kids have not signed yet.
Further observations on / at 1:10 PM revealed that hospice nurse started to provide care to Resident #5. Caregiver B assisted in reposition. Window was open while some Resident #5 ' s body areas were exposed and Caregiver A and Resident #6 were at the outside of the window.

In an interview on at 1:18 PM the Caregiver B stated " I am going to close it".

Class III

0052 Medication - Assistance with Self-Admin

Based on observation and record review, the Assisted Living Facility failed to follow the procedure during assistance with self-administration of medication for one (Resident #2) out of 14 sampled residents.

Findings included:

Observation on / at 11:31 AM the Administrator assisted Resident #2 with self-administration of medication. The Administrator stated "la medicina." the medication, pulled the medication card out and placed medication in Resident #2's hand and Resident #2 the medication in the resident's mouth. Initialed the medication observation record. Returned med to the cabinet and lock it. Administrator continued completing facility documentation and did not wash hands.

Review of Resident #2's medication observation record revealed that Resident #2 ' s medicine took Isosorb Dintab 30 mg- take one tablet at noon.

Class III

0054 Medication - Records

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SUMMARY STATEMENT OF DEFICIENCIES
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Based on observations, record review, and interview, the Assisted Living Facility to failed to have Medication Observation Records (MORs) with the names of the residents' health care provider and the health care provider's telephone number. The facility failed to record each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The facility failed to ensure the MORs were immediately updated after each time the medication is offered or administered.

Findings included:

Resident #1's MOR did not include health care provider's name and telephone number.
Review of Resident #1's MOR revealed that Artifi Tears Sol Op was not initialed as given on at 8 AM, Arthrts pain tab 650 mg was not initialed at 8 AM, 2 PM nor 8 PM any day for 2016, tab 2.5 mg was not initialed at 8 AM nor 8 PM any day for 2016, tab 1 mg, Multiple tab, - tab 1000 mcg nor C tab 500 mg were not initialed at 8 AM any day for 2016.

Reconciliation of Resident #1's medications revealed that C 500 mg tablets were missing in the morning from medication card from 1 thru 12. D3 tab 1000 mg were missing in the morning from medication card from 1 thru 12. tab 2.5 mg were mission in the morning from medication card from 1 thru 12, in the evening were from medication card from 1 thru 11. tab 1 mg were mission in the morning from medication card from 1 thru 12. pain tab 625 mg were mission in the morning from medication card from 1 thru 12, in the evening were from medication card from 1 thru 11. tab 1000 mg were mission in the morning from medication card from 1 thru 12.

Review of Resident #2's MOR did not include health care provider's name and telephone number.
Resident #2's MOR revealed that tab 800 mg was not initialed any day for 2016 up to 11 at 8 PM and it was initialed as given on / at 8 AM. Sulf tab 325 mg was not initialed any day for 2016 up to 11 at 8 PM.

Reconciliation of medication for Resident #2 revealed that tab 5 mg was in the medication card for at morning. tab 75 mg was in the medication card for at morning. tab 800 mg was in the medication card for at morning and tablets were missing from medication card from 1 thru 11. Sulf tab 325 mg were missing tablets from medication card from 1 thru 11.

Review of Resident #3's MOR did not include health care provider's name and telephone number.
Resident #3's MOR revealed that 200 mg tab, tab 81 mg , tab 75 mg,

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SUMMARY STATEMENT OF DEFICIENCIES
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tab 20 mg, tar tab 25 mg were not initialed as given on at 8 AM. tab 20 mg was not initialed as given on / at 8 AM and it was not initialed any day for 2016 up to 11 at 8 PM. tab 20 mg, tab 5 mg, tab 200 mg were not initialed as given on / at 8 PM. tab 5 mg was not initialed as given on , / and at 8 AM nor on , and / at 2 PM. tab 200 mg, tab 50 mg, were not initialed as given on , / and at 8 AM. cap 30 mg was not initialed as given on / and / syp 250/ 5 ml was not initialed any day for 2016 up to 11 at 8 PM. Arthrts pain tab 650 mg scheduled at 8 AM, 2 PM and 8 PM was not initialed any day for 2016 up to 11 at 2 PM and 8 PM and up to 12 at 8 AM. tab 2.5 scheduled at 8 AM and 8 PM was not initialed any day for 2016 up to 11 at 8 PM and up to 12 at 8 AM. tab 1 mg at 8 AM was not initialed any day for 2016 up to 12 at 8 AM. Multiple tab at 8 AM was not initialed any day for 2016 up to 12 at 8 AM. - tab 1000 mcg at 8 AM was not initialed any day for 2016 up to 12 at 8 AM. C tab 500 mg at 8 AM was not initialed any day for 2016 up to 12 at 8 AM.

Review of Resident #4's MOR did not include health care provider's name and telephone number. Resident #4's MOR revealed that tab 30 mg was not initialed as given on / / at 8 PM. tab 5 mg was just initialed on / at AM, after that it was not initialed anymore. tab 20 mg was initialed as given daily twice a day on 2016 until / at 8 AM. 800 mg tablets were initialed daily at 8 AM but it was not initialed any day of 2016 at 8 PM.

Reconciliation of medication for Resident #4 revealed that tab 20 mg in the evening were from medication card from 1 thru 12 except on 7. 800 mg tablets in the morning were missing from medication card from 1 thru 12 and in the evening from 1 thru 11.

Review of Resident #5's MOR did not include health care provider ' s name and telephone number. Resident #5's MOR revealed that tab 1 mg, tab 10 mg, Montelikast tab 10 mg, C tab 500 mg and cap 20 mg were initialed daily at 8 AM as given until - was not initialed as given on at 8 AM. tab 20 mg in the morning was initialed every day of 2016, from 1 thru 12. 800 mg was not initialed any day of 2016 at 8 PM and it was not initialed on / / at 8 AM.

In an interview on / at 11:02 AM the Administrator revealed that Medication Observation Records were initialed by Caregiver C.

Class III

0056 Medication - Labeling and Orders

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Based on observation and interview, the Assisted Living Facility failed to keep medication secure at all times.

Findings included:

Observation on / at 9:09 AM revealed that Resident #5 was resting in bed with half-bed rail up. There were two medicines unlocked in the hospital table next to Resident #5 ' s bed; medicines were: Megestrol AC Sus 40 mg/ml which was labeled for Resident #5 and 262 mg which was not labeled.

In an interview on / at 9:13 AM Caregiver A revealed that unlabeled medicine was for Resident #5.

Class III

0079 Staffing Standards - Levels

Based on interview, observation, and record review, the Assisted Living Facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern.

Findings included:

Observation on / at 8:55 AM revealed that the only caregivers in the facility were Caregiver A and Caregiver B taking care of 10 people. There were four females and two males sat in the living ; the females were in the recliner chair, one man in a recliner chair and another one in the recliner sofa. There were two female sat in the porch. Further observation on at 10:24 AM revealed that Caregiver D arrived to facility.

Review of facility's record revealed that staffing pattern for 2016 was posted in the Administrator's office. Schedule for / revealed that on showed Administrator on call, Caregiver A from 7 AM to 7 PM, Caregiver B from 7 PM to 7 AM, Caregiver C from 9 AM to 6 PM and Caregiver D was off.

In an interview on at 10:21 AM the Administrator revealed that it was the current staffing pattern.

In an interview on / / at 10:25 AM the Caregiver D revealed that Caregiver C was not working today.

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Class III

0083 Training - First Aid and

Based on observation, record review, and interview, the Assisted Living Facility failed to a caregiver who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times.

Findings included:

Observation on at 8:55 AM revealed that the only caregivers in the facility were Caregiver A and Caregiver B taking care of 10 people. There were four females and two males sat in the living ; the females were in the recliner chair, one man in a recliner chair and another one in the recliner sofa. There were two female sat in the porch. Further observation on / at 10:24 AM revealed that Caregiver D arrived to facility.

Review of facility's record revealed that staffing pattern for 2016 was posted in the Administrator office. Schedule for revealed that on showed Administrator on call, Caregiver A from 7 AM to 7 PM, Caregiver B from 7 PM to 7 AM, Caregiver C from 9 AM to 6 PM and Caregiver D was off.

Review of Caregiver A ' s personnel file revealed that there was no evidence of Caregiver A having completed First Aid and . Review of Caregiver B ' s personnel file revealed that there was no evidence of Caregiver B having completed First Aid and .

In an interview on / at 10:52 AM the Administrator stated "they don't have them."

Class III

0152 Physical Plant - Safe Living Environ/Other

Based observation and interview, the Assisted Living Facility failed to provide a safe and clean living environment to facility residents.

Findings included:

On / at 9:09 AM smelled a strong odor in the hallway where #2, #3 and #4 were.

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In an interview on at 9:10 AM Caregiver A confirmed that Caregiver A smelled in the hallway and stated " I haven't cleaned yet, we have to take care of many residents."

Observation on / at 8:55 AM revealed that There was a hole in one of the walls of the dining .

In an interview on / / at 10:52 AM the Caregiver D revealed that the hole in the wall was a wheelchair that hit the wall.

Class III

0161 Records - Staff

Based on record review and interview, the Assisted Living Facility failed to maintain personnel records for each staff member which contain, at a minimum, documentation of a copy of the employment application, background screening, and documentation of compliance with all training requirements.

Findings included:

Review of Caregiver C's personnel file revealed that there was no personnel file nor documents for Caregiver C available in the facility at the time of the survey.

In an interview on at 10:44 AM the Administrator revealed that Caregiver C's personnel record was at the other ALF.

Review of Caregiver A's personnel file revealed that there was no evidence of Caregiver A having completed a job application, and there was no result of background screening. Review of Caregiver B's personnel file revealed that there was no evidence of Caregiver B having completed a job application, and there was no result of background screening.

In an interview on / at 10:52 AM the Administrator revealed that Caregiver A and Caregiver B did not have the job application completed. They started working in the facility at the beginning of the month.

Class III

0162 Records - Resident

Based on record review and interview, the Assisted Living Facility failed to maintain a record for one

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(Resident #13) out of 14 sampled residents.

Findings included:

There was no record for Resident #13 in the facility at the time of the survey.

In an interview on at 12:35 PM the Administrator revealed that Resident #13 went to the hospital the same admitted date and when Resident #13 returned just stayed for two days and left. No contract was completed, nothing was completed.

Class III

Z815 Background Screening: Prohibited Offenses

Based on observation and record review, the Assisted Living Facility failed to ensure that caregivers have completed background screening level 2.

Findings included:

Review of Caregiver A's personnel file revealed that Caregiver A did not have background screening. Review of Caregiver B's personnel file revealed that Caregiver B did not have background screening.

In an interview on at 9:22 AM Caregiver B revealed that Caregiver B worked in the facility for 21 days.

In an interview on at 10:52 AM the Administrator revealed that Caregiver A and Caregiver B started working in the facility at the beginning of the month.

Unclassified

Z828 Administrative Fines: Violations

Based on observation and interviews, the Assisted Living Facility exceeded licensed capacity of 6, the facility had a census of 8 residents and day care participants.

Findings included:

Observation on at 8:55 AM revealed that Caregiver A and Caregiver B were taking care of 10

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clients. There were four females and two males sat in the living ; the females were in the recliner chair, one man in a recliner chair and another one in the recliner sofa. There were two female sat in the porch.

In an interview on ../.. at 8:59 AM Resident #6 revealed that Resident #6 lived in the facility, confirmed that Resident #6 ate breakfast, lunch and dinner plus took medications. Resident #6 did not leave the facility.

Observation on ../.. at 9:09 AM revealed that Resident #7 was observed resting in bed in #..

In an interview on / at 9:16 AM Caregiver A revealed that all residents observed at the facility lived in the facility but she doesn't think that she should say it.

In an interview on at 1:50 PM Resident #7 revealed that Resident #7 lived in the facility, confirmed that Resident #7 ate breakfast, lunch and dinner plus took medications. Resident #7 did not leave the facility.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[redacted], 2016

Administrator
Redland Alf Inc
20555 Sw 187 Ave
Miami, FL 33187
RE: CCR #2016004597 and 2016006946

Dear Administrator:

This letter reports the findings of a state licensure survey that was concluded on [redacted], 2016 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than [redacted], 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

XG90

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone:(305) 593-3100; Fax:(305) 593-3121
AHCA.MyFlorida.com