STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953432	09/06/2016
NAME OF PROVIDER OR SUPPLIER **EDEN GARDENS ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **12221 WEST DIXIE HIGHWAY** **MIAMI, FL 33161**	

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

0000 Initial Comments

A complaint inspection (CCR# 2016010073) was conducted at Eden Gardens ALF (License # 8209) on , 2016 through , 2016. Deficiencies were identified at the time of the survey:

0025 Resident Care - Supervision

Based on record review and interview, the facility failed to provide services appropriate to meet the needs of 75 out of 75 sampled residents (Residents # 1-75). The facility also failed to maintain a general awareness of the residents. Resident #1 was found in a nearby canal after an unreported absence from the facility. Resident #2 was found in her the facility, where the medical examiner estimates that she had been lying lifeless for approximately 24 hours.

Findings included:

1) During a financial monitoring conducted on , when asked if there had been any recent elopements, Staff A (Administrator) stated at approximately 12:30 pm that Resident # 1 had left the facility on Monday, , 2016 at about 9 pm and that he had been found in a nearby canal on Tuesday at about 5 pm.

During interview on Staff E stated on the phone at 11:28 am, "I worked on Monday night. I am a med tech. As far as I know Resident # 1 did not get his night medications (8:00 pm on Monday,). We start passing the night meds at 8 pm. Staff J was the last person to see him."
Record review showed that 8:00 pm medications for Resident #1 on were signed for by Staff E. A review of the medication bubble pack for Resident #1's 8:00 pm medications on showed that the medications were gone.

During interview on Staff J stated on the phone at 11:46 am, "I saw Resident # 1 at dinner time. At dinner time I did not see anything out of the ordinary for him. At 8:00 pm I went to his my round and his bed was not made and that was weird so I looked around and did not find him. I told the supervisor (Staff E) that he was not in his he said that he had probably gone out. We have a list of the residents that can go out and he was on the list. When I made my next round at 9 the bed was still the same and I told the supervisor again. When I left at 11 he had not come back yet. "

During interview on Staff K stated, on the phone at 12:15pm, "I saw Resident # 1 at 2:40 pm. He was always walking or sitting at the dining . I saw him also at dinner time (5:30 pm). The person at the front desk leaves at 8 and then we sit one hour each from 8 to 9, 9 to 10 and 10 to 11. I did the 10 to 11 and he was already reported as gone. He was always walking. He did not go out that much but he

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was always walking around the facility. At the snack time (8 pm) he was there, because I saw him. "

During interview on at 2:19 pm Staff E stated, "I got nervous because the guy was missing and I got and signed the medications."

On at 3:14 PM, interview with the detective in charge of Resident # 1's case stated that they received an anonymous call from a person that said there was a body floating in the canal, around 120th street and West Dixie Highway. The resident father's had filed a missing person report, and there had not been a rule on the cause of by the medical examiner. She did not know if the resident was alone or if he drowned.

During interview on at 6:13 am Staff F reported, Resident # 1 used to be up all night, between the living his unit, pacing. He used to go out sometimes, to the store, but he usually came back.

During interview on at 11:34 AM Staff C stated, "Resident # 1 did have a decrease in the Benzetropine about a month ago, and the doctor added the (30 mg) for . Maybe I called the doctor soon after the night shift reported that he was not sleeping." At 12:34 PM Staff C stated, "Two months before, yes, the staff reported he was unable to sleep, So I called the doctor and he added the sleeping medication, maybe I did forget to document that he was not sleeping well. After he was receiving the medication, the staff did not report any other changes."

During interview on at 10:58 am with Resident # 32 it was stated that he was Resident # 1's until 2 months ago. Resident #32 reported, Resident # 1 was up and down all night pacing because his meds weren't working. Resident # 32 told staff what was going on and asked staff to move him, but they moved Resident # 1 instead. He doesn't believe that Resident # 1 was taking his meds at all.

A review of Resident # 1's resident record showed that there was no documentation of Resident #1's change of condition.

During interview on at 2:21 pm, Staff C stated, "I informed Resident #1's change of condition to the facility's general practitioner. I told him he was not sleeping well. He did have a change of insurance so I know the Nurse saw him, but his Psychiatrist was another doctor. I do not remember when his insurance changed."

During interview on at 2:38, the ARNP said, "that day I saw numerous amount of patients and I got most of the resident's condition from the staff. It was my first time there and I do not remember that

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resident or if the staff mentioned any change in condition. I went through my list and I saw the residents, but it was a lot of residents to remember them all. I know that if their medication like the Benzetropine was too high, then I reduced the dosage. Like I said there was a large amount of resident and I do not remember them all."

During interview on at 2:25 PM, the psychiatrist of record, according to the facility's records stated, " I did not see that patient because he has [ ] Insurance as his insurance and I do not take residents that have this insurance."

A review of the facility's elopement policy showed that residents were to be re-evaluated annually to assess elopement risk.
A review of the most recent elopement assessment for Resident #1 showed that it was completed on .

2) On at 9:39 AM while investigating the elopement and of Resident # 1, another unreported was discovered, which had taken place at the facility. Staff C (Assistant Administrator) was asked about the resident that (Resident # 1). In response to the question about 'the resident,' who was a male, Staff C started to talk about a female resident. Staff C said, "she" (Resident # 2) was found in the . Resident #2 did not respond, and rescue was called. She said, Resident #2 of natural causes.

A review of Resident #2's health assessment (AHCA form 1823) showed that the resident required supervision with bathing and daily oversight.

An interview with Resident #2's primary care doctor on at 10:15 AM revealed, she saw her on and that the resident had medical diagnoses of severe and . She further stated, the resident had been previously walking with a walker and had recently declined. The doctor had prescribed a wheelchair for the resident.

Record review showed that there was no documentation of this change in Resident #2's condition in the facility's records.

In an interview with Staff F on at 6:35AM she stated, she worked the 11pm-7am shift. She said, part of her job required that she checked on the residents several times at night, first when she comes on shift 11:00PM, 3 AM and then 6 AM. She was observed with a paper with resident names which were assigned to her, there were markings indicating for that day. When questioned about Resident #2's , she stated that on Saturday at 11:30PM, she had seen the resident in

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her TV and the resident gave her the thumbs up sign. On Sunday morning, / at 6:30 AM she stated that she entered the resident's found the resident in the bathtub, with the water running, slumped over and unresponsive. She stated, the resident was not observed to have any bloody cuts/ and her skin was warm to the touch. She stated, she did not start ( ) but went out to get help from other staff. She stated, she called the Administrator, called 911 and the doctor. She stated that the Paramedics arrived to attend to the resident and informed her the resident had expired. She stated, that she had not checked the resident at 3 AM.

During an interview with staff F, Q and P on at approximately 6:05 am, all three staff stated that the facility's policy is to do rounds every 3 hours.

A review of the 'rounds sheet' for Saturday through Sunday, 20- , 2016, where staff initial next to each resident's name once they have observed the resident, showed that Staff F initialed the sheet at midnight, 3:00 am and 6:00 am to indicate that she had seen Resident #2.

During interview on at 12:55 pm, the police detective in charge of Resident # 2's case stated, "There was no way that she was alive 3 hours before she was found. She had been for a long time. She was unrecognizable and we needed to identify her in other ways."

During interview on at 5:00 pm, the police detective in charge on Resident # 2's case stated on the phone, " I impounded the medications and sent them with the body to the medical examiner office because we were not sure that she had of natural causes, she had been depressed. I would not say that she was decomposing but she had been for more than 10 hours. She was peeling away. The body removal people said that she had been for about a day. Her skin was purple. When we tried to lift her up the skin started to off."

During interview on at 12:52 pm, a worker from the medical examiner office stated regarding Resident #2, " I spoke to the medical examiner. She was decomposing. The decomposition process depends on various factors. The medical examiner thinks that she was close to 24 hours of being ."

A review of the Medical Examiner's report regarding Resident #2's , dated , shows that Resident #2 was found in a moderate state of decomposition described as "putrefaction decomposition." The report further documented, "The body is bloated, the skin is diffusely slipping, and there is dark red and green discoloration and marbling of the skin of the anterior aspect of the torso and upper and lower extremities. Patchy, faint, green discoloration is on the torso."

Interview on at 9:15 am, Resident # 59 stated that staff used to do bed checks once a day before Resident # 2 . He did not see Resident #2 all day on Saturday; no one did.

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Interview on [redacted] at 10:58 am, Resident # 32 stated that Resident # 2 didn't get up for breakfast, lunch or dinner Saturday. He kept knocking on her door, and finally when he didn' t get an answer, he notified staff J just before dinner, who advised him that 'some people just like to be alone.' He stated that staff knocked on Resident # 2's door, but no one went in that day. He woke up the next day (Sunday) and was told that Resident # 2 had [redacted]. He stated that during the day, staff does not do rounds or check on people. He further stated that sometimes at 3:00 pm, they will go into units and check on people, but not usually.

Interview on [redacted] at 12:03 pm, Resident # 43 stated, "I saw something wrong with Resident # 2 on Friday, and now I feel bad for not reporting it." He further stated, she kept falling asleep and that was unusual for her. He stated, he did not see Resident # 2 at all on Saturday. He said that staff knocked on the door of Resident #2's unit on Saturday but they didn't go in. Resident #60 stated that he gets checked in the morning but staff don't often come around in the evening.

Interview on [redacted] at 1:17 pm Staff H stated, "I did not enter her [redacted]. I knocked on the door around 7 or 8 at night (on Saturday, [redacted]) and the TV was on. I asked the residents that were listening to music, on the patio near Resident #2's [redacted], the ones in [redacted] or 49 and they said that she was watching TV. I did not open the door."

Interview on [redacted] at 9:22 AM Staff AA stated, "I was here Saturday the 20th in the morning, no I did not see Resident # 2. I asked at lunch time on Saturday for her and one resident, I do not remember the name, told me she might be out. All day Saturday I worked from 7 am- 3 PM and I did not see her."

Interview on [redacted] at 12:49 pm with Staff DD, regarding her initials, followed by an "X," on the rounds sheet for Saturday, [redacted] 20 on the 7am-3pm shift for Resident # 2, stated that the "X" means that the resident is out of the facility. Staff DD stated that some residents told her that Resident # 2 was out of the facility to attend a funeral, so she knocked on the door but didn't go in. She said that she saw her on Friday morning at breakfast and at lunch.

Interview on [redacted] at 10:23 AM, Staff X stated, "I work here both Friday and Saturday but I did not see Resident # 2 on Friday or Saturday. On Saturday ([redacted]), I helped out in the kitchen and I did not see her at all, the entire day."

Interview on [redacted] at 9:38 AM Staff BB (Housekeeper) stated, "Yes, I worked on Saturday in the morning, no, I did not see Resident # 2. The last time I saw her was Thursday around 11:00 AM, but Saturday I did not see her at all. "

Interview on [redacted] at 3:00 pm, a family friend who was listed as Resident #2's emergency contact stated that he had tried to call her cell phone twice on Saturday [redacted], but there was no answer.

Interview on [redacted] at 10:30 AM Staff R stated, "Every Monday we have an assigned area, the last

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time I saw Resident # 2 was on Friday the 19th, in the morning in the Patio. We have a sign in sheet with the time and we have to go to the , call the resident's name, we have to sign the sheet when the resident is ok, if there is no answer we have to go in the check if the resident is ok or check if the resident is out. "

Interview on at 10:47 AM Staff CC stated, "I worked on Friday and Saturday from 6:30 AM -3:30 PM, I did not see Resident # 2 at all that day on Friday, or Saturday."

3) A review of the staff communication log, resident records, the elopement log, and interviews with staff showed that there is a high prevalence of residents being out of the facility, even overnight, without staff knowing their whereabouts.
Record review found Resident #10's last health assessment (dated /) documented a medical history and diagnoses of , , , , and . Under physical limitations Resident #10's assessment documented slow gait with and imbalance. The resident requires assistance with bathing, dressing, , and toileting. The facility's resident observation log documented that Resident #10 had a history of that result in the resident being transferred to the hospital with injuries. On at 2:53 PM Resident #10 down and hit his head, staff observed the resident with a cut on the right elbow. Staff contacted the doctor (Dr.) and per Dr's order, he was transferred to hospital." On it was documented "resident from time to time loses his balance." On at 7:30 PM, "resident was found on the floor on the patio area from his forehead on the front right side." Rescue was called and resident sent to hospital and was discharged on . On at 11:30 AM, " resident was reported to have on the 3-11 shift on . Resident again today at around 7:00 AM. Doctor was called and per doctor's order " resident was sent to the hospital. On at 10:23 PM " resident was found on the patio by staff, alleged that he since the pavement was wet he hit his head and got a bump, injured his knee and leg.' Resident #10 was again sent to the hospital. On , " resident came back with a on the forehead and knee and hip was bandaged." On at 2:57 PM, the resident alleged to the 3-11 shift that he down. Staff observed the resident with small cuts and and a bump on the forehead, also he was losing balance and very weak. Staff notified the doctor again and per doctor's order, the resident was sent to the hospital. Based on record review the facility had not had any preventions in place to prevent Resident #10 from falling other than sending the resident to the hospital after a .
A review of the facility's census for showed that there were 118 residents. There were 112 residents in the facility, and the other six residents were hospitalized. A review of the staff schedule confirmed that there were three staff scheduled to provide care for the 112 residents.
Interview on at 6:05 am, Staff Q stated that 3 people were on duty. He further stated that this shift (11pm-7am) was always staffed with only 3 people. Asked how he communicates with the other 2 staff if he or a resident need assistance while he is around the facility, he said that the staff have no

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walkie talkies; they communicate via their personal cell phones.
Interview on at 6:08 am, Staff Q stated, " I just showered some of the residents. I showered the guys. Staff P is showering some of the women. " He said that he did not know the facility's census, but that he follows the rounds sheet which he is given a copy of. He said that they conduct rounds at 12 midnight, 3:00 am and 6:00 am. He goes into each make sure everyone is ok. They start showers at 5:00 am, and they focus on the people who can't shower alone. He showers Resident #17, who he says needs 3 people to help him. Sometimes Resident #17 fights the staff.
Interview on at 6:13 am with Staff F, when asked whether residents leave during the night she stated that some residents insist on going out, but they try not to let them out. Some residents insist on going out at around 6:30 am. They go to the convenience store, but they usually come back.
4) Interview on at 6:21 am Resident # 9 was in the shower alone. The resident is . Staff Q said that he assists the resident with showering, and he has already laid his clothing out. When Staff Q was asked if he needed to stay at the attend to the resident, he stated that he did not, because the resident would eventually get out. When asked if the resident was at risk of falling, Staff Q said he thought the resident would be alright.
5) Interview on at 7:02 am Staff F said that sometimes Resident # 57 is out all night. This happens about once a week. Sometimes he says he's out on business, but other than that, he does not tell them his whereabouts and staff does not know where he goes.

6) Record review of Resident # 32 revealed that on he was admitted to hospital complaining of not feeling well. He was discharged with a recommendation for follow-up with the Primary Care Physician within 1-2 days. Review of facility's progress note dated / indicated that the resident informed staff he was going out to visit a friend. The administrator was notified. No additional note was in the record regarding the resident's return to facility with discharge hospital paperwork and the need for a follow up appointment.
On at 10:30AM, Resident #32 was observed with a dried approximately 2 x 2 inches, black, scabbed with debris attached to , on his left knee. The resident stated that he was allowed to come and go from the facility. He stated that on Saturday , he had on the pavement, scraping his knee. He stated that he did not seek any treatment but he had informed a caregiver at the facility. He stated that the was now very and he wanted someone to look at it.
On at 12:00PM the Administrator stated that she had been at the facility all weekend and had spoken with Resident # 32 but she didn't notice his knee. She stated that she had been notified by the night staff via text on at 1:30AM that he had returned from an outing at a friend's house. She stated that she didn't know he had been in the hospital.

7) A review of Resident # 34's resident record revealed that he has diagnoses of and also . There was an order from his medical doctor dated / / stating that he was able to self-administer his medications including . The resident has a guardian

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(for financial affairs only).
On / at 12:30 pm , Resident # 34 stated that he was and was on until the past month. He stated that he doesn't check his sugar because he "knows when it is high." He has chosen not to take stating it hurts his . He reported, he had 3 in place and on . The resident had rambling conversation, going from one topic to another, lost track of topic he was asked about. The resident was angry about guardianship take all his money they are criminals. Have millions they have stolen from me.
In an additional interview with Resident #34 on / at 1:00PM he stated that he was independent and did not require any assistance from the facility. He stated, he "preferred that the staff stay out of his his business." In an observation of the resident's the interview, the extremely cluttered with papers, books, personal items, clothing stacked 3-4 feet high, leaving only a small narrow pathway around the resident's bed. Resident #34 stated that he did not need the court appointed guardian and became visibly angry and used numerous derogatory terms to describe the guardianship. Resident #34 stated, he self- administered his own medications and had dependent . He stated that over the past month of , he had stopped taking the prescribed since it was "bad for his condition." The resident was questioned if he was testing his sugar levels and the resident stated that he had stopped monitoring his sugar levels since " I know when my sugar is elevated based on my vision." The resident stated that he goes out to his primary physician, his and other and coordinates his own care but he had not informed any physician that he had stopped taking his . The resident continued with his conversation, moving from topic to topic in long rambling sentences.
Interview on / at 11:05 AM Staff C stated, she was informed by Resident # 34 himself that he was not taking his during and she did not contact any physician or his guardian. She further stated, the resident made his own decision not to take since he had a prescription to self-medicate. She stated she did not call his physician or guardian.
In an interview on at 9:25 am, Resident # 34's primary care physician stated that the resident has been his patient for a long time. He stated the resident is noncompliant with medications. He further stated that Resident #34 missed his last appointment, has and makes bad decisions. He stated that he felt the resident was able to administer his own medications but he makes poor safety decisions and has a history of not taking his medications. He stated that if the facility administered the medications, the resident would probably refuse also. He stated that he had not been notified that the resident was not taking his or checking his sugar. He also stated that Resident # 34 believes aliens live in the ocean and he is mad the Navy released him.
A review of Resident # 33's resident record revealed that he was sent to the hospital on at 22:00 complaining of all over pain and lack of appetite. The resident he came back on at 1:00 am. There was no documentation of any observation or monitoring of resident after returning from the hospital.
In an interview with the Administrator on / at 11:15 AM she stated that she was aware that

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Resident #33 had gone out to the hospital for evaluation. She stated that she was unable to provide any documentation of any observations made by the staff of the resident upon his return from the hospital.
Interview on at 8:55 am Staff C stated, "The residents that go in and out all the time do not sign but they come to the nurse station to let us know. If they go to an appointment or out with their family we write it down on the Shift Report Book. "
On at approximately 3:30 pm Residents # 58 and 59 were not seen at 12, 2. Staff EE documented "unknown" in the shift report book regarding their whereabouts.
Interview on at 10:16 am Resident # 40 stated, "I do not feel there is enough staff to take care of people, and that's the problems they have, they do not have enough girls to help people out."
Interview on at 11:07 am Resident # 41 stated, " I don't know if there is enough staff for all the persons here, I don ' t think so, but I wouldn ' t know. The staff here, they have their favorites. "
Interview on at 11:18 am Resident # 31 stated, "In my opinion I do not think there are enough people to care of the residents."
Interview on at 12:20 pm Resident # 60 stated, "Well, I do not think there is enough staff for the people."
Interview on at 8:09 am Resident # 24 stated, "there are no phones in the , if I need help, then, I wait for them to pass by when they announce breakfast."
Interview with Resident #54 on / at 1:40 PM regarding staff at the facility it was reported, "My only complaint is that they are busy, if someone calls their name, they will pass them by without acknowledgment. As a resident I feel we need to be acknowledged. Some of the staff are busy."
Interview on at 10:56 AM Resident # 46 stated, " If there is a need at night or an emergency, there is no help. The lady that helps at night is rude, so I don't ask her for help with adult brief changes because she said I have to do it on my own. There is nobody here to ask for help at night. I do not know her name."

Class I

0030 Resident Care - Rights & Facility Procedures

Based on record review, interview and observation, it was determined that the facility failed to honor resident rights to live in a safe and decent living environment, free from neglect and , to be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy, and to have access to adequate and appropriate health care consistent with established and recognized standards within the community, for 75 out of 75 sampled resident records reviewed (Resident #1-75). Resident #2 was found in her living unit, and appears to have been for approximately 24 hours before being discovered by staff. The facility had bedbugs and roaches which were not being adequately treated by pest control services. The facility had several owned and stray cats freely roaming the environment. There was no evidence the animals had immunizations.

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Several residents personal dignity was consistently ignored by staff when staff changed adult briefs, bathed or dressed residents in the presence of others.
Findings included:

1. During the survey on it was discovered that Resident #2 was found in her bathtub at 6:00 AM on , 2016.
Record review showed Resident #2 ' s health assessment dated documented the following diagnoses: , ( ), ( ), , major , . She was independent with ambulation, eating, toileting, transfers, supervision with bathing, dressing, self-care and medication management.
Interview on at 12:55 PM, the detective investigating Resident #2's reported "there was no way that she was alive 3 hours before she was found. She had been for a long time. She was unrecognizable and we needed to identify her in other ways. "
Interview on at 1:17 PM Staff H stated, the following regarding Resident #2, " I did not enter her . I knocked on the door around 7 or 8 at night and the TV was on. I asked the residents that were listening to music, the ones in or 49 and they said that she was watching TV. I did not open the door because she was independent and did not need to be supervised. "
Based on interview with Staff H, Resident #2 was not observed during the required rounds per the facility's protocol. The staff member did not enter the observe Resident #2's whereabouts.
Interview on at 11:48 AM with staff from the medical examiner's office reported, "we have to ID (identify) the body. She was decomposing." A later review of the Medical Examiner's report dated showed that the body was identified by X-rays from the primary physician as Resident#2.
Interview on at 4:45 PM Staff G stated, "Staff F called 911. Resident was checked at 12:00 AM by Staff F and she was in bed. That was the last time that she was seen alive."
Interview on at 12:52 PM with staff from the medical examiner's office reported, "I spoke to the medical examiner. She was decomposing. The decomposition process depends on various factors. The medical examiner thinks that she was close to 24 hours of being ."
On at 5:00 pm phone interview with the detective revealed, " ...She had been for more than 10 hours. She was peeling away. The body removal people said that she had been for about a day. Her skin was purple. When we tried to lift her up the skin started to off. "
Interview with Staff F on at 6:35 AM she stated that part of her job responsibility/assignment required that she checked on the residents several times at night, first when she comes on shift 11:00PM, 3 AM, and then 6 AM. She was observed with a paper with resident names which were assigned to her, there were markings indicating for that day. When questioned about Resident #2's , she stated that on Saturday at 11:30PM she had seen the resident in her TV and the resident gave her the thumbs up sign. On Sunday morning, / at 6:30 AM she stated that she entered the resident's found the resident in the bathtub, with the water running, slumped over and unresponsive. She stated the resident was not observed to have any

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bloody cuts/ and her skin was warm to the touch. She stated she did not start ( ) but went out to get help from other staff. She stated she called the Administrator, called 911 and the medical doctor (MD). She stated that the emergency medical technicians (EMTs) arrived to attend to resident and informed her the resident had expired. She stated that she had not checked the resident at 3 AM. When questioned if she initiated when she found the resident, she stated that she had not. She stated that she was not sure which residents had ( ).

In an interview with Resident #2 ' s physician on at 10:15 AM she stated that she evaluated Resident #2 monthly at her office location, and last saw the resident on . She stated that Resident #2 was alert, oriented and able to administer her own medications. The physician stated that the resident utilized a walker but had recently declined physically and she had ordered the resident a wheelchair. She stated that she had questioned the resident about her feelings since her ex-husband's and determined the resident had no thoughts or worsening from the event.

Interview at 7:02 AM 7:02 am with Staff G, who was on duty the morning of / when Resident #2's body was found. She stated, "I was at the front desk. Staff F made rounds and found her. Staff called me and I told Staff F to call 911. I went to get all of the resident's paperwork together. I went to the , saw her in the tub. The water was running and it was right up to the top of the tub. I touched her. She was hard. She was slumped in the tub; her face was down. She was turning colors. Her back was black on the butt. There was an odor in the unit. I smelled ' ." It wasn't a high smell, but I could smell it. "

2. On at 9:07 AM in unit 56, interview Resident #54, she stated that she has bedbugs in a bottle. She collects them off of her body. (Photo of jar containing bedbugs taken). Stated that there is an exterminator but they only do a partial job. Her partner's mattress was just replaced a couple of days ago but hers has not been replaced yet. She continues to get bitten every night. Feels that her other belongings are but the exterminator has not provided assistance with this. Said that the problem has been going on for 4 months & that the interventions done by staff are not sufficient and she is miserable.

A review of a state agency health inspection of the facility and pest control records showed that the facility, including resident #55's unit, was being treated for bedbugs.

Record review found the staff communication book stated on two residents "got physical " over the other eating his banana. On , a female resident was complaining that a male resident was " harassing her. Further record review of each resident's record showed that there was no documentation that the facility spoke to either resident regarding this behavior. On , Resident #52 threw a chair at his , hitting him. He also pulled a knife on the . Staff intervened and police were called.

3. Observations in on at 6:30 AM found a resident with a half full urinal in his hand, no privacy screen was observed in the .

Staff Q stated on at 6:30 AM, the resident uses the urinal at his bedside.

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On / at 5:10 AM observed Staff O assisting Resident #27. Resident #27 was in bed, staff assisted the resident to get out of bed with transfer to wheelchair, the resident had difficulty to transfer to the chair, staff removed Resident #27's clothes with open in front of her , two agency staff present in front of the door and a resident male resident in the hallway. Resident #27 was fully nude in the wheelchair, staff proceeded to bathe the resident in shower, the resident was able to stand in the shower, but would constantly complain about not being able to stand for a long period of time. Staff O assisted Resident #27 in getting out the shower, placed her adult brief on, and sat her topless in the wheelchair, again in front of her , and agency staff without closing the resident's door or to ensuring the privacy of the resident.
Further observations on / after 5:10 AM found three staff members attempting to assist Resident #17 whose pants were down as his adult brief was being changed on the bed and later he was being dressed in the middle of the . His was present and the was open. All three staff members were needed to transfer him to the wheelchair and he was unable to assist.

Class I

0032 Resident Care - Elopement Standards

Based on observation, record review and interview, the facility failed to follow its own elopement policies for 33 out of 75 sampled residents (Resident #1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 35, 45, 47, 48, 49, 50, 51, 52 and 53). Elopement assessments were not conducted annually, as the facility's policy outlines. The facility also failed to conduct elopement drills twice a year.

The Findings include:

A review of the staff communication log, resident records, the elopement log, and interviews with staff showed that there is a high prevalence of residents being out of the facility, even overnight, without staff knowing their whereabouts. A review of the facility's elopement policy showed that residents were to be re-evaluated annually to assess elopement risk.

A review of the most recent elopement assessments for Residents #1, 9, 35 and 37 showed that they were completed on .

Interview on , when asked if there had been any recent elopements, Staff A (Administrator) stated at approximately 12:30 pm that Resident # 1 had left the facility on Monday, , 2016 at about 9 pm and that he had been found in a nearby canal on Tuesday at about 5 pm.

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Interview on at 3:14 PM, the detective in charge of Resident # 1's case stated that they received an anonymous call from a person that said there was a body floating in the canal, around 120th street and West Dixie Highway. The resident father's had filed a missing person report, and there had not been a ruling on the cause of by the medical examiner. She did not know if the resident was alone or if he drowned.

Interview on at 8:55 am Staff C stated, "The residents that go in and out all the time do not sign but they come to the nurse station to let us know. If they go to an appointment or out with their family we write it down on the Shift Report Book." She also stated on at 10:30 am, "We do an elopement assessment for every resident."

A focused review of 118 resident records on showed that an elopement assessment had not been completed for 27 residents.
Interview on at 7:02 am Staff F said that sometimes Resident # 57 is out all night. This happens about once a week. Sometimes he says he's out on business, but other than that, he does not tell them his whereabouts and staff does not know where he goes.
The facility has an Elopement Risk List; there were 23 individuals identified as elopement risk on the elopement risk list. Residents # 3, # 4, # 5, # 6, # 7, # 8, # 9, # 10, # 11, # 12, # 13, # 14, # 15, #16, #17, # 18, # 19, # 20, # 21, # 22, # 23, # 24 and # 25.
On at 8:00 am Resident # 17 was observed and he did not have an elopement risk or anything to identify he is an elopement risk. His name was on the elopement risk list.
On at 8:02 AM Resident # 9 was observed and he did not have an elopement risk or anything to identify he is an elopement risk. His name was on the elopement risk list.
On at 8:09 am Resident # 24 was observed and he did not have an elopement risk or anything to identify he is an elopement risk. His name was on the elopement risk list.
A review of 100% of facility elopement assessments showed:
Resident # 4 was identified as an elopement risk on the elopement risk assessment dated , but her health assessment dated did not identify her as elopement risk. She was on the elopement risk list.
Resident # 6 was identified as an elopement risk on the elopement risk assessment dated , but her health assessment dated did not identify her as elopement risk. She was on the elopement risk list.
Resident # 3 was not identified at elopement risk on the elopement risk assessment dated , but his health assessment dated identified him as elopement risk. He was on the elopement risk list.
Resident # 23 had no assessment risk done, but her health assessment dated / identifies her an elopement risk; she was also in the list of residents at elopement risk.
Resident # 45 had 2 Resident status/Potential Risk Factors and had 1 Definitive Risk Factor. As per the

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facility's Elopement Risk Assessment if scoring 2 Resident status/Potential Risk Factors and had 1 Definitive Risk Factor the resident must be identified at elopement risk. The resident was not identified at elopement risk; his health assessment dated / did not identify him an elopement risk and he was not on the elopement risk list.

Resident # 35 had 2 Resident status/Potential Risk Factors and had 1 Definitive Risk Factor. As per the facility's Elopement Risk Assessment if scoring 2 Resident status/Potential Risk Factors and had 1 Definitive Risk Factor the resident must be identified at elopement risk. The resident was not identified an elopement risk; his health assessment dated / did not identify him an elopement risk and he was not on the elopement risk list.

Resident # 19 was not identified an elopement risk on the elopement risk assessment dated , but his health assessment dated identified him as elopement risk; he was also in the list of residents as an elopement risk.

Resident # 5 had 3 Resident status/Potential Risk Factors on his elopement risk assessment dated . As per the facility's Elopement Risk Assessment if scoring 3 Resident status/Potential Risk Factors and/or one or more Definitive Risk Factor the resident must be identified an elopement risk. The resident was not identified an elopement risk; his health assessment dated did not identify him as an elopement risk, but he was on the elopement risk list.

Resident # 18 had no elopement risk assessment done; he was identified as an elopement risk on the health assessment dated and he was on the elopement risk list. Record review revealed that he had eloped on / .

Resident # 10 had no elopement risk assessment done; he was identified as elopement risk on the health assessment dated / and he was on the elopement risk list.

Resident # 22 had no elopement risk assessment done; he was not identified as elopement risk on the health assessment dated / ; but he was on the elopement risk list.

Resident # 47 was identified at elopement risk on the elopement risk assessment dated and there was no other elopement assessment risk done afterwards. The health assessment dated did not identify her as an elopement risk and she was not on the elopement risk list.

Resident # 48 had 3 Resident status/Potential Risk Factors on her elopement risk assessment dated and she was not identified as an elopement risk and there was no other elopement assessment risk done after. Her health assessment dated did not identify her an elopement risk and she was not on the elopement risk list.

Resident # 49 had no elopement risk assessment done; he was not identified as an elopement risk assessment on the health assessment completed on .

Resident # 50 was identified as an elopement risk in the elopement risk assessment dated and was identified at elopement risk on the health assessment dated ; he was not on the facility's elopement risk list.

Resident # 51 had no elopement risk assessment; she was not identified as an elopement risk on the health assessment dated and she was not on the elopement risk list.

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Resident # 21 was identified as an elopement risk on the elopement risk assessment dated . Her health assessment dated did not identify her an elopement risk and she was not on the elopement risk list.
Resident # 52 had no elopement risk assessment; he was not identified as an elopement risk on the health assessment dated and he was not on the elopement risk list.
Record review revealed that the last Elopement Drill was conducted on . Also revealed that there were only 17 pictures in the Elopement Risk Binder when the facility had 23 residents identified at risk of elopement.

Class II

0052 Medication - Assistance with Self-Admin

Based on observation, interview and record review, the facility failed to ensure that unlicensed persons providing assistance with administration of medication did so in accordance with procedures described in Rule 58A-5.0191, F.A.C., Section 429.256, F.S.

Findings:

On at 6:54 am, observed medication pass. Staff Y did not inform residents of what medications they were being handed. She did not consistently watch them swallow the medications, often turning away before they did so.
On at 6:55 am, Staff Y stated that she was not aware that she needed to tell them what medications they were taking.
On at 10:36 am, observed resident #75 and another resident coming to get 8:00 am medications.
On at 10:36 am, Staff Y stated that she did not know that the meds needed to be given within one hour before or after 8:00 am. Stated that these residents always came for meds late.
Class III

0054 Medication - Records

Based on observation, interview and record review, the facility failed to maintain an accurate daily medication observation record (MOR) for residents. This was evidenced by the failure of the nurse to accurately document the prescribed medications that were administered on the MOR, for 3 of 75 sampled residents (Resident #13, #28 and #31).

Findings include:

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Record review of the 2016 Medication Observation Record (MOR) for Residents #13, #28 and #31 indicated no documentation that the residents had been administered their medications as prescribed. Additionally, no documentation was readily available with the daily glucose testing results as ordered by the physician.

Review of Resident #13' s 2016 MOR form indicated that the resident required medication management and skilled nursing to administer . Review of the 2016 MOR indicated that Resident #13 had a diagnosis of dependent and was prescribed 35 units every morning and 22 units every evening. Further review of the 2016 MOR indicated no documentation that the had been administered. The form only indicated " Home Health Nurse " written next to the medication order and glucose testing order.

Review of Resident #28 ' s 2016 MOR form indicated that the resident required medication management and skilled nursing to administer . Review of the 2016 MOR indicated that Resident #28 had a diagnosis of dependent and was prescribed Lantus 25 units every evening. Further review of the 2016 MOR indicated no documentation that the had been administered. The form only indicated " Home Health Nurse " written next to the medication order and glucose testing order. Review of the 3rd Party Provider flow chart dated - indicated Resident #28 had been administered her dose in the morning. Further review of Resident #28 ' s medical record indicated a physician order dated to administer Lantus 25 units in the AM. The 2016 MOR was inaccurate and did not reflect the current physician order.

Review of Resident #31 ' s 2016 MOR form indicated that the resident required medication management and skilled nursing to administer . Review of the 2016 MOR indicated that Resident #31 had a diagnosis of dependent and was prescribed 10 units every morning and evening, and additionally Lantus 15 units every evening. Further review of the 2016 MOR indicated no documentation that the had been administered. The form only indicated " Home Health Nurse " written next to the medication order and glucose testing order.

In an interview with the Home Health Nurse on at 7:30AM, he stated that he does not sign the facility MOR which indicated that he administered the prescribed . He stated that he records the medication administered and glucose testing results in his agency documentation only. He stated that he will verbally report any concerns to the medication technician on duty.

In an interview with the Administrator on at 10:30AM she was questioned about the facility

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policy for medication documentation. She stated that the facility policy indicated that when medication is administered to the resident, the MOR must be completed at that time. She stated that the facility did not employ nurses, but contracted with a Home Health Agency to provide a nurse who would conduct glucose testing and administer to the residents as ordered by their physician. The Administrator stated that she would expect that the ordered glucose monitoring and administration be completed by the nurse and documented in the resident ' s MOR. She stated that she was unaware that the glucose testing results and administration documentation had not been completed by the 3rd party provider nurse in the facility MOR.

Class III

0055 Medication - Storage and Disposal

Based on observation and interview, the facility failed to appropriately secure prescribed resident medication. This was evidenced by the failure to centrally store medications, including and supplies for residents in the nursing office at the facility.

The findings include:

In an observation on at 7:30AM, the door to the nurses station, where all medications are stored, was observed unlocked and open. Several large blue bins were observed stored inside the office space. Each bin held medications delivered by the pharmacy for the entire month of 2016. The bins contained medications, including . Random residents were observed to enter the location, look around the office and retrieve rolls of toilet paper from behind the door. A medication refrigerator with bottles of was observed inside the work space where residents were allowed to enter unsupervised. On the counter, medical supplies were observed, including a filled biohazard waste container with used needles and syringes. Residents were observed lining up outside the medication allowed to enter the .
In an additional random observations of the medication and conducted during the survey, the large bins with medications remained inside the , available for anyone to open the lids and remove the contents. Numerous stacks of medication cards were observed on desk tops, propped against the floor and on counter tops.(see photos).

On at 8:44 am, observed the medication wide open, client chart cabinet open, medication cabinet unlocked, Staff Y (medication technician) in the dining . Observed an unidentified resident enter the medication pour herself a cup of water from the pitcher on top of the med cabinet.

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On at 12:03 pm, Resident # 43 stated, " I don't think they should let residents into the med they don't watch people take them. There are always pills on the floor and people could pick them up and take them."
On at approximately 2:00 pm, observed the medication the door standing open and the file cabinet containing resident records open. Medications were on counters in bubble packs, and had been left there during the process of staff logging the medications in. No facility staff was present.
In an interview with the Administrator on / at 12:00PM she stated that the office was being utilized as the nursing station/ medication also used by the Home Health Nurse to administer to the residents at the facility. The Administrator stated that her expectations were that the door to the nurses station/medication , be locked and secured when personnel are not physically present. She stated that the stacks of medication cards were the . medications delivered by the pharmacy and were being organized by the Assistant Administrator. She stated that the organization process took days to accomplish. When questioned about the security of medications in the open bins, she stated that the door to the always locked and residents do not have access to the medications.

On at 10:28 am, observed medications on all of the desks in the med . Resident #33's medications were on a desk. Controlled meds including , on the counter near the resident record cabinet.
On at 10:28 am,Staff #43 stated that Resident #33 self-administers his medications, and that he brought them to be signed in. She further stated that the controlled medications were to be placed in the cabinet, but that they were recently delivered.

Class II

0076 **(DNROs)**

Based on record review and interview the facility failed to provide ( ) to a resident without for 1 out of 75 sampled residents (Resident # 2). Also the facility failed to have adequate Policies and Procedures regarding ( ).
Findings included:
In an interview with Staff F on at 6:35AM she stated that on Sunday morning, / at 6:30 AM she entered Resident # 2 ' s found the resident in the bathtub, with the water running, slumped over and unresponsive. She stated she did not start but went out to get help from other staff. She stated she called the Administrator, called 911 and the Medical Doctor. She stated that the Emergency Medical Technicians (EMT ' s) arrived to attend to resident and informed her that the resident had expired. She stated that she had not checked the resident at 3 AM. When questioned if she

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initiated when she found the resident, she stated that she had not. She stated that she was not sure which residents had . To determine if a resident had a , she stated that she would need to come to the nurse ' s office to look inside the resident ' s chart, to determine if a was in place. She stated that the facility had no policy that she was aware of, to alert staff which residents had a signed in place. She stated that she had no concerns with any papers since " the night shift doesn ' t have the need for ' s. "
In an interview on at 6:55 Am Staff Y stated she that she was not sure if facility has list of residents on , but if she found resident unresponsive would begin , call for help and have staff look into residents chart for paper. She would start and have other staff call 911.
In an interview on approximately at 3:00 pm the administrator confirmed that if there is anyone in the facility is found unresponsive, staff come to the office to look at the files to determine whether the resident has a before providing . She further stated that she didn ' t believe that any current residents had a .
Record review revealed that Resident # 36 had a in his file that was signed on .
Class III

0077 Staffing Standards - Administrators

Based on observation, interviews and record review, the Administrator failed to ensure that the facility was adequately operated and maintained, and that the staff was adequately managed to provide appropriate care to 58 sampled residents (within resident sample #1-75). Resident supervision and care, physical plant conditions, and multiple procedural, training and paperwork processes did not meet regulatory standards. Multiple residents were harmed by these deficient practices, including Resident #1, who was found after an unreported absence from the facility lasting longer than 24 hours, and Resident #2, who was found in her , estimated to have been undiscovered for around 24 hours.
Findings:
Interviewed on / at approximately 3:00 pm, the Administrator stated that she did not have documentation of having completed the required 12 hours of continuing education available on site for review. She stated that she could provide documentation of her 12 hours of continuing education only if she was able to have it faxed over from another facility.
Observations in the facility from 24- 6 showed numerous severe, deficient practices resulting in harm or potential harm to residence. Non-adherence to terms outlined in statute in many areas, including Supervision of adult residents, resident rights and facility procedures, staffing standards, elopement standards, physical plant concerns, medication storage and disposal, was also identified.
Interviews conducted with staff #B- EE from 24- 6 documented several instances of

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staff not knowing facility policies or procedures to provide assistance to residents.
Interviews with multiple residents from 24- 6 documented several concerns about the inadequacy of assistance or attention being received from staff.

Class III

0079 Staffing Standards - Levels

Based on observation, interviews and record review, the facility failed to ensure adequate staffing to meet scheduled and unscheduled resident needs for 75 of 75 sampled residents (Residents # 1-75). This inadequate supervision contributed to the deaths of Residents # 1 and 2. Resident #1 was found in a nearby canal a day after his unexplained absence from the facility. Resident #2 was found in her bathtub at the facility more than 24 hours after she was last seen alive by facility staff.
The Findings include:
Interviewed on at 6:05 am, Staff Q stated that 3 people were on duty. He further stated that this shift (11pm-7am) was always staffed with only 3 people. Asked how he communicates with the other 2 staff if he or a resident need assistance while he is around the facility, he said that the staff have no walkie talkies; they communicate via their personal cell phones.
On at 6:08 am, Staff Q stated, " I just showered some of the residents. I showered the guys. Staff P is showering some of the women." He said that he did not know the facility's census, but that he follows the rounds sheet which he is given a copy of. He said that they conduct rounds at 12 midnight, 3:00 am and 6:00 am. He further stated that he and the other staff start showers at 5:00 am, and they focus on the people who can't shower alone. He showers Resident #17, who needs 3 people to help him.
On at 6:21 am, Observed that resident #9 was in the shower alone.
On 6:21 am, Staff Q stated that Resident #9 is . Staff Q said that he assists the resident with showering, and that he had already laid the resident's clothing out. Asked if he needed to stay at the attend to the resident, Staff Q stated that he did not, because the resident would eventually get out. Asked if the resident was at risk of falling, Staff Q said he thought the resident would be alright.
On at 6:21 am, observed that Resident #9 was in the shower unassisted by staff throughout the tour of the facility (approximately 45 minutes).
A review of the staff communication book showed that on , Resident #52 left the facility without staff noticing on the 3-11 shift. The time of his exit was unknown.
On at 7:02 am- Staff F said that sometimes Resident # 57 is out all night. Staff F further stated that this happens about once a week. Staff F said "Sometimes he says he's out on business, but other than that, he does not tell us his whereabouts and we does not know where he goes."
On at 9:15 am, Resident #55 stated that once a day, staff used to do bed checks before Resident #2 .

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On at 10:58 am, Resident #32 stated that he was Resident #1's until 2 months ago. He reported, Resident #1 was up and down all night pacing because his meds weren't working. He told staff what was going on with Resident #1 because Resident #1's actions were making it hard to sleep for 2 or 3 days. He further stated that that Resident #2 didn't get up for breakfast, lunch or dinner on Saturday ( ). He kept knocking on her door, and finally when he didn't get an answer, he notified staff just before dinner, who advised him that 'some people just like to be alone.' He stated that staff knocked on Resident #2's door, but no one went in that day.
On at 12:03 pm, Resident #43 stated, 'I saw something wrong with Resident #2 on Friday ( ), and now I feel bad for not reporting it." He further stated that she kept falling asleep. This was unusual for her. She used to visit Resident #43's a lot. On Friday night she was sleeping in the chair in his . He stated that he did not see Resident #2 at all on Saturday. Staff knocked on the door of her unit on Saturday but they didn't go in. He stated that he gets checked in the morning but staff don't often come around in the evening.
On at 12:49 pm, interviewed Staff #DD regarding her initials, followed by an X, on the rounds sheet for Saturday, 20 on the 7am-3pm shift for resident #2. She stated that the X means that the resident was out of the facility. She stated that residents told her that Resident #2 was out of the facility to attend a funeral, so she knocked on the door but didn't go in.
Interview on at 12:55 pm, the Medical Examiner (ME) staff stated that they were told that the resident was alive 3 hours before they arrived, and there was no way that this could have been true. The ME further stated that the resident was not visually recognizable and had to be identified through other means. The ME stated that their office does not give an exact time of because of the many variables involved, however she had skin slippage when they tried to remove the body. The ME said that a better estimate of time of is around 24 hours.

A review of Resident # 32's record revealed that on he was admitted to hospital complaining of not feeling well. He was discharged with a recommendation for follow-up with Primary Care Physician within 1-2 days. A review of facility progress note dated / indicated that the resident informed staff he was going out to visit a friend. The Administrator was notified. No additional note was in the record regarding the resident's return to facility with discharge hospital paperwork and need for a follow up appointment.
On at 10:30AM, Resident #32 the resident was observed with a dried 2x2 inches, black, scabbed with debris attached to , on his left knee. The resident stated that he was allowed to come and go from the facility. He stated that on Saturday , he had on the pavement, scraping his knee (photos). He stated that he did not seek any treatment but he had informed a caregiver at the facility. He stated that the was now very and he wanted someone to look at it.
A review of Resident # 33's facility record revealed that he was sent to the hospital on at 22:00 complaining of all over pain and lack of appetite. The record further indicated that the resident came

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back on at 1:00 am. There was no documentation of any observation or monitoring of resident after returning from the hospital.
In an interview with the Administrator on / at 11:15 AM she stated that she was aware that Resident #33 had gone out to the hospital for evaluation. She stated that she was unable to provide any documentation of any observations made by the staff of the resident upon his return from the hospital.

On at 10:16 am Resident # 40 stated, " I do not feel there is enough staff to take care of people, and that ' s the problems they have, they do not have enough girls to help people out. "
On at 11:07 am Resident # 41 stated, " I don ' t know if there is enough staff for all the persons here, I don ' t think so, but I wouldn ' t know. The staff here, they have their favorites. "
On at 11:18 am Resident # 31 stated, " In my opinion I do not think there are enough people to care of the residents. "
On at 12:20 pm Resident #43 stated, " Well, I do not think there is enough staff for the people. "
On at 10:56 am Resident 46 stated, " If there is a need at night or an emergency, there is no help. The lady that helps at night is rude, so I don ' t ask her for help with adult brief change because she said I have to do it on my own. There is nobody here to ask for help at night. I do not know her name. "
Observations on / after 5:10 AM found three staff members attempting to assist Resident #17 whose pants were down as his adult brief was being changed on the bed and later he was being dressed in the middle of the . His was present and the was open. All three staff members were needed to transfer him to the wheelchair and he was unable to assist.
On / at 1:40 PM regarding staff at the facility, Resident #54 stated. "My only complaint is that they are busy, if someone calls their name, they will pass them by without acknowledgment. As a resident I feel we need to be acknowledged. Some of the staff are busy. "

Class I

0090 Training -

Based on record review and interview the facility failed to ensure that 2 out of 30 sampled employees had a ( ) training within 30 days of hire. (Staff Q and Staff H).

Findings included:

Record review of personnel file of Staff Q revealed that she was hired to work on ; also revealed that there was no training in the file.

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Record review of personnel file of Staff H revealed that there was no training in the file.

On at 1:17 pm Staff H stated: " I was hired on ".

The administrator stated on at 3 pm that she will review her staff files to make sure that they are complete.
Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation and interview, the facility failed to provide a safe living environment for 75 of 75 sampled residents (#s 1-75). The facility had torn chairs, debris in areas used by residents, and non-working toilets. The facility also had bedbugs and roaches which were not being adequately treated by pest control services. The facility had several owned and stray cats freely roaming the environment; the animals did not have immunizations.

Findings included:

On at 7:50 am observed in TV all of the chairs were ripped and had holes on them.

On at 12:03 pm Resident # 60 stated, "Rain Gutters are needed in the corner. When we try to get into the dining , we get wet."
On / at 5:35 am the toilet near unit 26 was clogged. There was no shower curtain in one . The floor in the shower was dirty and the outlet cover was coming off. The wall near was chipped away.

On at approximately 6:30 am observed a lot of debris-wood, broken TV screen, used oil, etc.- in the back area. In there was the odor of .
On at 9:02 am- unit 58- observed 3 cats inside and outside of the unit. Cat food was on the floor. Resident # 54 stated, that "these are my babies."

On at 9:07 am- unit 56- observed one cat on the bed. Residents stated that this was their cat, who is an indoor cat. Resident # 55 stated that she has bedbugs in a bottle. She collects them off of her body. (Photo of jar containing bedbugs was taken). Stated that there is an exterminator but they only do a partial job. Her partner's mattress was just replaced a couple of days ago but hers has not been replaced yet. She continues to get bitten every night. Resident #55 feels that her other belongings are but the exterminator has not provided assistance with this. Said that the problem has been going on for 4 months & that the interventions done by staff are not sufficient and she is miserable. Her

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partner, Resident # 55, showed an open space behind an electrical outlet, stating that he believes the bedbugs are coming from there. He also picked up a glue trap from under the refrigerator, showing several roaches attached to it (photo).
A review of a state agency health inspection report for the facility, and pest control records, showed that the facility, including resident #55's unit, was being treated for bedbugs. Further review of the state agency health inspection report showed that there were several stray and non-immunized cats living at the facility.
Interviewed on at 1:40 PM, Resident #55 stated, " In 15 years, we never had a bed bug problem. She showed marks on the arm, every morning about 2 or 3 AM I get bitten. This started four months ago. They changed my 's beds, sprayed. He gets a bite every now and then."
On at 1:10 pm requested to have the Resident # 30 to be opened to verify that the resident was out of the facility.

On at 1:10 pm the facility administrator stated that Resident # 30 was out of the facility on pass with her parents and that Resident # 30 would not allow the facility to have a copy of her she loves her privacy and that her father was supposed to bring the key 2 days before and he did not.

On at 1:15 pm the father of Resident # 30 stated on the phone that Resident # 30 would be back at the facility the following Tuesday and that he was not able to go to the facility on the day that he was supposed to go and that he would be there the next day to return the key.

Class II

0163 Records - Resident. Penalties for Alteration

Based on interviews and record review, the facility fraudulently altered, defaced or falsified medical or other records.

Findings:

1)
During a financial monitoring conducted on , when asked if there had been any recent elopements, Staff A (Administrator) stated at approximately 12:30 pm that Resident # 1 had left the facility on Monday, , 2016 at about 9 pm and that he had been found in a nearby canal on Tuesday at about 5 pm.

On at 3:14 PM the detective in charge of Resident # 1 ' s case stated that they received an anonymous call from a person that said there was a body floating in the canal, around 120th street and

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West Dixie Highway. The resident father ' s had filed a missing person report , and there had not been a rule on the cause of by the medical examiner. She did not know if the resident was alone or if he drowned.

On Staff J stated on the phone at 11:46 am: " I saw Resident # 1 at dinner time. At dinner time I did not see anything out of the ordinary for him. At 8:00 pm I went to his my round and his bed was not made and that was weird so I looked around and did not find him. I told the supervisor (Staff E) that he was not in his he said that he had probably gone out. We have a list of the residents that can go out and he was on the list. When I made my next round at 9 the bed was still the same and I told the supervisor again. When I left at 11 he had not come back yet. "

On Staff E stated on the phone at 11:28 am: "I worked on Monday night. I am a med tech. As far as I know Resident # 1 did not get his night medications (8:00 pm on Monday, /). We start passing the night meds at 8 pm. Staff J was the last person to see him."

Record review showed that 8:00 pm medications for Resident #1 on were signed for by Staff E.

A review of the medication bubble pack for Resident #1's 8:00 pm medications on showed that the medications were gone.

On at 2:19 pm Staff E stated: "I got nervous because the guy was missing and I got and signed the medications."

2)

In an interview with Staff F at 6:35AM she stated that part of her job required that she checked on the residents several times at night, first when she comes on shift 11:00PM, 3 AM and then 6 AM. She was observed with a paper with resident names which were assigned to her, there were markings indicating for that day. When questioned about Resident #2's , she stated that on Saturday at 11:30PM she had seen the resident in her TV and the resident gave her the thumbs up sign. On Sunday morning, / at 6:30 AM she stated that she entered the resident ' s found the resident in the bathtub, with the water running, slumped over and unresponsive. She stated resident was not observed to have any bloody cuts/ and her skin was warm to the touch. She stated she did not start but went out to get help from other staff. She stated she called the Administrator, called 911 and the MD. She stated that the EMTs arrived to attend to resident and informed her the resident had expired. She stated that she had not checked the resident at 3 AM. When questioned if she initiated when she found the resident, she stated that she had not.

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During an interview with staff F, Q and P on at approximately 6:05 am, all three staff stated that the facility ' s policy is to do rounds every 3 hours.

A review of the 'rounds sheet' where staff initial next to each resident's name once they have observed the resident showed that Staff F initialed the sheet on - / at midnight, 3:00 am and 6:00 am to indicate that she had seen Resident #2.

On at 12:55 pm the police detective in charge of Resident # 2 ' s case stated: " There was no way that she was alive 3 hours before she was found. She had been for a long time. She was unrecognizable and we needed to identify her in other ways. "

On at 5:00 pm the police detective in charge on Resident # 2 ' s case stated on the phone: " I impounded the medications and sent them with the body to the medical examiner office because we were not sure that she had of natural causes; she had been depressed. I would not say that she was decomposing but she had been for more than 10 hours. She was peeling away. The body removal people said that she had been for about a day. Her skin was purple. When we tried to lift her up the skin started to off. "

On at 12:52 pm, a worker from the medical examiner office stated: " I spoke to the medical examiner. She was decomposing. The decomposition process depends on various factors. The medical examiner thinks that she was close to 24 hours of being . "

Class III

0165 Risk Mgmt & QA: Adverse Incident Report

Based on record review and interview, the facility failed to file an incident report within 1 business day after the occurrence of an adverse incident for 12 out of 75 sampled residents (Resident #1, 2, 17, 21, 52, 60, 68, 69, 70, 71, and 73).

Findings include:

On surveyor was investigating the elopement and of Resident #1 another unreported was discovered at the facility; Resident #2 was found in her bathtub at 6:00 AM, on Sunday /.

Review of the facility in-house incident log revealed:
-on at 10:45 PM Resident #53 had a physical altercation with Resident #72, Resident #53

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was complaining of back pain and injury to the leg and was sent to the hospital.
-On at 2:00 PM Resident #73 had a in the Patio.
-On Resident #76 had a and was sent to hospital. On at 7:15 PM Resident #17 had a and suffered a laceration on right side of upper eyebrow.
- On at 1 PM Resident #63 escorted Resident #74 in wheelchair to the store, on the way back Resident #74 had a in the parking lot and hurt her right knee and right shoulder, resident was sent to hospital.
-On Resident #75 suffered a , hurt her back and was sent to the hospital.
-On at 9:00 AM Resident #52 slipped and suffered a , hurt her in dining area.
-On at 10:45 AM Resident #71 suffered a . Hurt her knee and abdomen, and was taking to the hospital.
-On , Resident 53, threw a chair at his (Resident #72), hitting him, He also pulled a knife on the . Staff intervened and police were called. Resident #53 was complaining of back pain and injury to the leg and was sent to the hospital.
-On Resident #2 was found in her , faced down, Resident #2 had ,
-On Resident #1 was found in the canal close to the facility, resident was .
A review of the AHCA incident report database showed that the incident report about Resident #1 was filed more than one day after the resident disappeared.
Review of the AHCA Incident report database revealed, the last incident report the facility filed prior to Resident#1's was on .

On at 11:32 AM, the Administrator stated that the incident report was not filed for Resident #2 because she of natural causes and staff did not file the rest of the incidents because they thought they were not required to report them.

Class III

L243 LMH - Training

Based on record review and interview the facility failed to ensure that staff receive a minimum of 6 hours of specialized training in working with individuals with mental health diagnoses within 6 months of employment in a limited mental health facility for 2 out of 30 sampled employees (Staff G and K). The facility also failed to have a 3 hours update of limited mental health training every 2 years for 4 out of 30 sampled staff (Staff A, J, N and P).

Findings included:

Record review of Staff G revealed that she was hired to work on ; also revealed that she did a 3

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hours training in limited mental health on / . There was no initial limited mental health training in her personnel record.
Record review of Staff K revealed that she had no application in her personnel record; also revealed that she had no limited mental health training in her record.
Record review of Staff J and Staff N revealed that they both did a 3 hours update in limited mental training on / . Record review of Staff P revealed that the 3 hours training was completed on .

On at 9:55 am Staff K stated on the phone that she was transferred from Courtyard to Eden Gardens on or of 2015 and that her application and her limited mental health training must be at Courtyard.
The administrator (Staff A) stated on at 3 pm that she will review her staff files to make sure that they are complete.
Record review of Staff A revealed that she had the last 3 hours update of limited mental health training on / .

Staff A stated on / at 1:00 pm: " I am aware that I have to update my Limited Mental Health training; however, there is a class right now going on about that. "

Class III

Z813 Results of Screening & Notification in File

Based on observation, record review and interview the facility failed to have documentation of Attestation of Compliance with Background Screening inside 29 of 30 sampled staff (A - DD) files.

Findings included:

Observation on / at 11:00 am showed facility ' s updated staff schedule reflected staff (A -DD) working in the facility.

Record review revealed staff (A-DD) had their eligible Level II background screening results in file, but the Attestations of Compliance with Background Screening were missing.

During an interview on / around 3:00 pm Staff A and C acknowledged that Staff (A - DD) worked in the facility, but they did not have Attestations in their files at the time of the survey.

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Z816 Background Screening-Compliance Attestation

Based on record review and interview the facility failed to provide a new Eligible Level II background screening for an employee who had a break in service for more than 90 days for one out of 30 sampled employees (Staff H).

Findings included:

A review of Staff H ' s personnel record revealed that her Level II Background Screening was dated and had an Eligible status.

On at 1:17 pm Staff H stated: " I was hired on ."

On at 2:55 pm, the Administrator stated that Staff H used to work in a restaurant in Hialeah before coming to work.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Eden Gardens Alf
12221 West Dixie Highway
Miami, FL 33161

RE: CCR #2016010073

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 24 2016 through , 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 , 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 Sonia Bailey, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure 2016010073
XG90

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RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

9/16/2016

. Imogen Robinson, Administrator
Eden Gardens ALF
12221 West Dixie Highway
Miami, FL 33161

Dear ..... Robinson,

This letter reports the findings of a licensure complaint survey (CCR#) conducted ..... 2016- , 2016 by representatives of the Agency for Health Care Administration. Attached is the provider's copy of the State (5000) Form, which indicates there were deficiencies noted during the inspection.

The inspection resulted in findings of non-compliance in the following areas:

1) St-A0025- Class I- Supervision

The facility failed to provide services appropriate to meet the needs of 78 out of 78 sampled residents (Residents # 1-78). The facility also failed to maintain a general awareness of the residents. Resident #1 was found in a nearby canal after an unreported absence from the facility. Resident #2 was found in her the facility, where the medical examiner estimates that she had been lying lifeless for approximately 24 hours.

2) St-A0030- Class I- Resident Rights

The facility failed to honor resident rights to live in a safe and decent living environment, free from neglect and , to be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy, and to have access to adequate and appropriate health care consistent with established and recognized standards within the community, for 78 out of 78 sampled resident records reviewed (Resident #1-78). Resident #2 was found in her living unit, and appears to have been for around 24 hours before being discovered by staff. The facility had bedbugs and roaches which were not being adequately treated by pest control services. The facility had several owned and stray cats freely roaming the environment; the animals did not have immunizations. Several residents' personal dignity was consistently ignored by staff when staff changed adult briefs, bathed or dressed the residents in the presence of others.

3) St-A0079- Class I- Staffing Standards

The facility failed to ensure adequate staffing to meet scheduled and unscheduled resident needs for 78 of 78 sampled residents (Residents # 1-78). This inadequate supervision contributed to the deaths of Residents # 1 and 2. Resident #1 was found

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in a nearby canal a day after his unexplained absence from the facility. Resident #2 was found in her bathtub at the facility more than 24 hours after she was last seen alive by facility staff.

4) St-A0032- Class II- Elopement Standards

The facility failed to follow its own elopement policies for 33 out of 78 sampled residents (Resident #1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 35, 45, 47, 48, 49, 50, 51, 52 and 53). Elopement assessments were not conducted annually, as the facility policy outlines. The facility also failed to conduct elopement drills twice a year.

5) St-A0055- Class II- Medication Storage and Disposal

The facility failed to appropriately secure prescribed resident medication. This was evidenced by the failure to centrally store medications, including and supplies for residents in the nursing office at the facility.

You are directed to complete the following tasks:

A) The facility must develop policies and procedures for daily and promptly identifying and assessing residents changing needs for supervision and support. These policies and procedures must include the following elements:

- An identification of the parties responsible for maintaining daily awareness of resident needs for supervision and support.
- A description of how residents are assessed to determine that they are at not at risk of danger to themselves or to/from others when they are in the community unescorted.
- A description of how identified resident needs for supervision are documented in the resident record, and of how these needs, and the plans to address them, are communicated to staff across all shifts.
- A description of how residents' concerns or needs for staff assistance, brought to any staff member's attention, are shared with the management team and how the management team acts upon these reports from staff.
- The maximum timeframe for documenting the supervision need after it is first observed or reported.
- The required timeframe within which the follow up action must occur.

This task must be completed by .

B) The facility must ensure that the environment is free from pests by obtaining effective pest control services from a licensed pest control company with treatments for all pests infesting the facility, including bedbugs and roaches. The facility must have a copy of the signed contract and treatment plan available for review.

The facility must develop policies and procedures for eliminating bedbug infestations which include a provision that allows for resident property being brought into the facility to be screened for bedbugs.

The facility must maintain immunization records for all cats or other pets owned by residents, and must ensure that these records are always kept current.

The facility must eliminate conditions that lead to the housing of stray cats on the premises, and must eliminate the presence of stray cats.

The facility must have a satisfactory Department of Health Inspection (DOH), and must maintain documentation of this on site and available for review by Agency personnel.

These tasks must be completed by .

C) The facility must retrain all staff about resident rights, respect and personal dignity. The training should be performed by someone who does not currently work in the facility or within the group of facilities operated by the same leadership; possibly the Long Term Care Ombudsman Program. The facility must maintain documentation of the training's content and attendance on site and available for review by Agency personnel.

This task must be completed by .

D) The facility must develop procedures for ensuring residents' personal dignity during the receipt of personal services including bathing, and changing of adult briefs. The facility must provide and document supervision to ensure that staff are following these procedures. Records of supervision must be maintained on site and available for review.

This task must be completed by .

E) The facility must revise the staffing pattern to ensure that the facility is always adequately staffed to meet scheduled and unscheduled resident needs, especially on the evening, overnight and weekend shifts. Specifically, the number of staff available must be determined by residents' needs for supervision and assistance on all shifts instead of meeting regulatory guidelines only during Monday-Friday, day hours. Schedules must be constructed to ensure that weekend, evening and overnight staff-to-resident ration ensures that enough staff is present to provide adequate care.

The facility must develop and document a process whereby staff can inform management of insufficient staffing, or of an inability to meet resident needs. This process should include an identification of the parties responsible for making additional staffing available, and a timeline within which changes will be made. The documentation of this process, and records of staff training on the process, must be available for review.

An accurate staff schedule reflecting staffing levels sufficient to meet residents' needs must be posted and adhered to at all times, and available for review.

These tasks must be completed by .

F) The facility must truthfully and accurately document and maintain daily sheets recording that rounds have been made and each resident's whereabouts are known every two hours. The daily rounds sheets must contain the initials of each staff person who is attesting to having made the rounds visually observed each resident or having confirmed residents' attendance at an activity off of the facility.

The facility must retrain staff on this process. Documentation of the content of and attendance at the training must be available for review.

These tasks must be completed by .

G) The facility must reassess elopement risk on all current residents, as documented by the presence of an accurate and updated elopement assessment in each resident file.

The facility must implement elopement precautions as identified in the facility's policy and procedure, for all residents identified as at risk of elopement at the time of assessment.

The facility must retrain staff about elopement procedures. Documentation of the content of and attendance at the training must be available for review.

The facility must conduct one elopement drill wherein all facility staff are trained, and then must conduct drills twice annually as identified by statute. The facility must keep records of the immediate elopement drill and all subsequent drills on site and available for review by Agency personnel.

These tasks must be completed by .

H) The facility must hire a pharmacy consultant who is a licensed pharmacist or registered nurse to review and revised medication policies and procedures.

This task must be completed by .

I) The facility must train staff on the updated medication policies and procedures, and must keep records of this training on site and available for review by agency personnel.

This task must be completed by .

Any required documentation set forth above which is not to be maintained on site and/or in resident records, should be directed to the attention . Sonia Bailey, Health Facility Evaluator Supervisor and sent to:

Agency for Health Care Administration
Health Quality Assurance, Miami Office
Attention: Sonia Bailey
8333 NW 53 Street, Suite 300
Miami, Florida 33166
Phone: (305) 593-3151

Fax: (305) 593- 3121

Nothing in this Directed Plan of Correction limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call Sonia Bailey, Miami Field Office, at (305) 593-3106.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager