RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Floridian Gardens Assisted Living Facility
17250 Sw 137 Avenue
Miami, FL 33177

Dear Administrator:

This letter reports the findings of a Complaint (CCR# 20160110153) inspection survey conducted on , 2016 and concluded on , 2016, by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC).

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

St - A - 0025 - 429.26(7) Fs; 58a-5.0182(1) Fac - Resident Care - Supervision Class II
St - A - 0079 - 58a-5.019(3) Fac - Staffing Standards - Class II

Directed Corrective Actions:

1. 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 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.
    - The facility must train staff on these policies and procedures. Documentation of the content of, and attendance of all staff at, the training must be available for review.

These tasks must be completed by //

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2. 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.

3. 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.

4. The facility must train staff on this process. Documentation of the content of, and attendance of all staff at, the training 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 .

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact . Laura Manville, Survey and Certification Support Branch, at (727) 552-1955 Sonia Baily, Health Facility Evaluator Supervisor, Miami, (305) 593-3100

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve

D7JR

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	AL11968608	10/04/2016
NAME OF PROVIDER OR SUPPLIER **FLORIDIAN GARDENS ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **17250 SW 137 AVENUE MIAMI, FL 33177**	

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

0000 Initial Comments

A Complaint Survey (CCR2016010153) was conducted from through . Floridian Gardens with Limited Mental Health component (License #12489) had the following deficiencies identified at the time of the survey:

0010 Admissions - Continued Residency

Based on observation, record review and interview, the facility failed to ensure the appropriateness of continued residency for 1 of 60 sampled residents (Resident # 10).

Findings:

On at 11:05 a.m. during a facility tour Resident #10 was observed in with ten other residents who later discovered to be receiving hospice care (Residents #1-9 and Resident #11). No staff were present.

A review of Resident #10's health assessment (AHCA form 1823) dated) showed diagnoses of , , , decreased memory, general decline, and also showed that the resident needed assistance with all Activities of Daily Living (ADLs) and self-administration of medications. Further review showed that under "nursing /treatment/ service requirements", "hospice service" was needed. Continued review showed that there was a prescription from a doctor for Resident #10 / / for the resident to receive hospice care. There was no documentation that Resident #10 was receiving hospice care.

On at 2:25 p.m. the Administrator and facility RN stated that Resident #10 was not ambulatory and was not admitted to hospice care, by mistake.

Class III

0025 Resident Care - Supervision

Based on observation, record review and interview, the facility failed to provide care and services appropriate to meet the needs of 168 of 168 residents. The facility failed to provide adequate daily observation and personal supervision to prevent resident choking, and with injury. Resident #21 choked during lunch and became , resulting in hospitalization and transfer to a rehabilitation facility. Eleven hospice residents (Residents 1-11) were unsupervised by staff when Resident # 6 and cut her head. Several residents who needed assistance with toileting were found with adult briefs

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filled with or feces, which had been unchanged for several hours.
Findings:
1)
On at 11:05 A.M. observed Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11 alone in #, without staff supervision.
Record review showed that Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, and #11 were assigned to hospice care, and Resident # 10 was in need of hospice care but had not been enrolled in hospice.
On at 11:06 A.M., observed Resident #6 standing up from her chair unassisted, and walking 3 or 4 steps. The resident then tried to sit, however no chair was behind her and she in sitting position on the floor trying to hold on to her wheelchair. Resident #6 hit her head on the wheelchair's armrest, and the cut began to .
On at 10:55 AM Staff A revealed that residents in # constantly stand and have risk of . She was worried that Resident #48 would .
A review of the records for Residents ' #1-11 and Resident #48 showed:
Resident #1's health assessment (AHCA form 1823) dated had Diagnoses ( ) of ( ), and Resident needed assistance with all activities of daily living (ADLs). The Resident's Hospice Interdisciplinary (ID) plan of care review dated revealed resident had , and alteration at risk.
Resident #2's health assessment (AHCA form 1823) dated had diagnoses ( ) of ( ), and . Resident needed assistance with all ADL ' s. The Resident's Hospice (ID) plan of care dated / revealed that the resident was at risk of .
Resident #3's health assessment (AHCA form 1823) dated had diagnoses ( ) of ( ), ( ), II, . The resident needed assistance with ambulation, bathing, dressing, self-care, toileting and transferring. The hospice interdisciplinary (ID) plan of care dated revealed resident was chair and bed bound. The treatment goal was to not experience injury, and to remain safe.
Resident #4 ' s health assessment (AHCA form 1823) dated had diagnoses ( ) of ( ), ' s . Further review showed that Resident #4 needed assistance with all ADL. The resident's hospice interdisciplinary (ID) plan of care dated revealed that the resident needed assistance with ADL and potential for injury.
Resident #5's health assessment (AHCA form 1823) dated had diagnoses ( ) of ' s, II, ( ), ( ). Resident #5 needed supervision with ambulation, eating, toileting, transferring and assistance with bathing, dressing, and self- care. The hospice interdisciplinary (ID) plan of care dated revealed that Resident #5 needed assistance with activities such as transfer to prevent injuries.
Resident #6 ' s health assessment (AHCA form 1823) dated had diagnoses ( ) of ( ), . Further review showed that that resident

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needed assistance with ambulation, toileting, transferring and assistance with bathing, dressing and self-care. The resident needed precautions.
Resident #7's health assessment (AHCA form 1823) dated had diagnoses ( ):
Hydrocephaly (idiopathic), S/P VP ( ), ( ), ( ). The resident needed assistance with ambulation, bathing, dressing, self-care, toileting, and supervision with eating and transferring. Resident #7 's records showed that she was under precaution.
Resident #8's health assessment (AHCA form 1823) dated had diagnoses ( ):
( ), ( ), ( ), Resident #8 needed supervision with bathing, dressing, self-care and toileting.
Resident #9's health assessment (AHCA form 1823) dated had diagnoses ( ):
( ), ( ), chronic , ( ), II. Resident #9 needed supervision eating, self-care, toileting and transferring.
Resident #10's health assessment (AHCA form 1823) dated / had diagnoses ( ) of ( ), ( ), Decreased memory, under nutrition and general decline. Resident #10 needed assistance with ambulating, bathing, dressing, self-care, transferring and toileting and self-administration of medications. Further review showed that under "nursing /treatment/ service requirements", "hospice service" was needed. Continued review showed that there was a prescription from a doctor for Resident #10 for the resident to receive hospice care. There was no documentation that Resident #10 was receiving hospice care.
Resident #11's health assessment (AHCA form 1823) dated had diagnoses ( ):
Parkinson's ( ), . Resident #11 needed assistance with ambulation, bathing, dressing, self-care, toileting and transferring.
Resident #48's Health Assessment (AHCA form 1823) dated had diagnoeses of Parkinson's . The resident was alert and oriented X2 and needed a puree diet.

2)
A review of the facility's internal incident reports showed that Resident #21 choked during lunch on . The resident stopped breathing and became . Though the record reflect that the resident had a hearbeat, was initiated and the resident was transported to the hospital by Emergency Medical Services.
On at 2:08 p.m. the Administrator stated that she was called when Resident #21 was eating fast on the south wing dining #. She further stated "Resident #21 was choking and staff called 911. Resident was taken to the hospital, and from the hospital was transferred to the rehabilitation center."
Record review showed Resident # 21 was admitted to the facility on / and discharged on / . Health Assessment (AHCA from 1823) diagnoses ( ): ( ),

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. A review of Resident #21's transfer form dated showed " Broncho , ." " Resident was transferred to the hospital, via rescue at 1:30 PM " . The Observation log dated on showed: " the nurse was called to the dining area for an emergency with the Resident #21, upon arrival noted the patient ( ) did not respond. The nurse proceeded with the other nurse to give ( ) to the patient ( ). After getting help from an employee to call rescue, remained receiving until paramedics arrive. The left the facility with rescue at 1:30 PM ." On at 9:53 AM, Staff G stated that on the day of the incident with Resident #21, she was working alone in South Dining #2. She further stated that there were 35 residents in that dining , and it was too much. She was on the other side from where he was eating and the other staff was bringing the drinks. She heard someone coughing, immediately moved to next section of the dining found him. His face was red. She screamed and Staff H came from the other dining , put the resident ' s arms up, put gloves on and tried to start removing his and food from his mouth.

On Staff F stated during a telephone interview, regarding Resident #21 choking in the dining : "Resident #21 was sitting at the table eating lunch with his mother, who lived here. I passed by to the kitchen and someone called me and I run and saw one of the CNAs helping him with Heimlich maneuver, removed the . I started and called for help and asked the other nurse to call the rescue. The beat never was lost. We did the compression and breathing. I started the compression. The whole body was . When I started the , it looked that resident had something obstructing his breathing. He was sitting but he was too tall and heavy. Another staff and I started the . We did two sections. I compressed first and Staff B did breathing. It was impossible due to he was heavy." Staff F was asked to clarify if was started while the resident still had a heartbeat, and she stated that it was. Staff F was asked to clarify if the resident had been placed on the floor when the Heimlich maneuver was attempted, and she restated that staff 'did compressions' when the resident to the floor.

On at 1:58 PM Staff A4 stated regarding the incident involving Resident #21 " we were serving lunch to all the residents in this . Resident #21 ate very fast and starts coughing. The resident turned red. We called the registered nurse (RN) that was nearby."

On at 11:40 AM, observed Resident #1, sat in a wheelchair with one pillow at each side between himself and wheelchair in South Dining # I with a cup with water in front of him. There was no one else in the . Record review showed the resident needed assistance with all ADL. Observation on at 12:30 PM revealed that there were 16 residents in the South Dining two hospice residents, Resident #1 and Resident #51, and no staff members. The Administrator was walking in the hallway and was informed. The Administrator stated " Oh, two staff members are in the other dining none in this one."
On at 7:32 AM, observed that there were 14 residents in wheelchairs and one resident in a

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regular chair in the West Dining # . There were no staff members supervising. Further observed Resident #48 constantly standing up and down in her wheelchair. Record review showed that the resident needed precautions.
On at 7:37 AM observed that Resident #47 was in West dining # , sitting in his wheelchair chewing a plastic bag without supervision or intervention from staff.
3)
On / at 10:41 AM, Resident # 18 stated " We do not have administration here for more than 3 months. We did not have staff during night time, we need more staff at his facility to help us. "
On , at 10:15 AM, Resident # 30 stated " Staff is very slow because facility does not have staff. If I need help I yell and Staff took time to come here . At some point, I 'm neglected because I need to do many things that I cannot do, since I need assistance with that. Staff are tired they need help. "
On at 8:56 AM observed Resident #7 was transferred from the activity # in wheelchair while she moved wheelchair to her feet, Staff Y assisted Resident #7 with transferring from wheelchair to recliner.
On at 8:58 AM Staff Y revealed she did not provide resident care, she just provided activities to the residents.
On at 6:15 AM, observed Resident #45 was in the hallway outside # calling one caregiver for changing her who had a bowel movement a long time ago, and the horrible with the feces odor and no one could stand inside the .
On at 6:30 AM observed Resident #10 was in # resting on bed with half-bed rail up and revealed that no one has changed her incontinence brief and she had a bowel movement and was unable to put the bed rail down by herself. "
On at 6:40 AM Resident #45 stated " I have been reported it since four in the morning, but night shift just wanted to sleep. "
On at 6:42 AM interview with Resident #10 told to Day Shift ' s Supervisor " You can solve the problem in 10 minutes, you just need to bring me in the . "
On at 6:42 AM observed Staff X walk into Resident #10's , and stated " Yes, Resident #10 told me, but I am only one. "
On at 6:46 AM observed that the area in front of the West Nurse ' s station smelled like .
On at 1:10 PM observed that between # and #413 there was a strong smell.
On at 11:00 AM interview with Staff A revealed " You are right, we need more employees. "
On at 11:00 AM, Resident #27 ' s daughter revealed that early in the year, in , her mother was dropped on the floor by staff, broke her forehead and went to the hospital. She further stated " There was less staff on the weekend, I have reported to Administrators and Supervisors. Last Saturday my mom did not eat and no one fed her."

On at 11:58 AM Staff A revealed that caregivers have told the Administrator about families'

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complaints about short staff on weekends, and the Administrator passed those concerns on to the facility ' s owners. Staff A stated that the Facility's owners ' response was that new employees would be hired, but nothing had happened yet. Staff A further stated that "Resident #27 ' s daughter placed a complaint today ( ) but the facility has not started the investigation yet."

Record review showed the facility had documented the following residents' in the last month:
Resident # 7 on , was heard screaming at 5:10 am, was found on the floor with a on her forehead, and was transported to the hospital by ambulance. A review of the hospital record showed that the resident was treated for a nasal bone .
Resident # 12 on .
Resident # 6 on and obtained a superficial open on her skull.
On at 11:51 AM Staff W confirmed that Resident #12 during afternoon shift on Monday or Sunday.

Class II

0030 Resident Care - Rights & Facility Procedures

Based on observation and interview, the Assisted Living Facility failed to ensure that one (Resident #9) out of 60 sampled residents was treated with dignity and respect for the need for privacy. The facility failed to ensure that five of 60 sampled residents (Residents # 54, 31, 18, 19, 31) could participate in community services and activities provide staff who could communicate with residents The facility also failed to provide a clean living environment.

Findings included:

Observation on at 6:10 AM revealed that # ' s door was open and Resident #9 was wearing only briefs. Staff L stated " Please remember to close the door " .

On at 6:15 AM, observed Resident #45 was in the hallway outside # calling one caregiver for changing her who had a bowel movement a long time ago, and the horrible with the feces odor and no one could stand inside the .
On at 6:30 AM observed Resident #10 was in # resting on bed with half-bed rail up and revealed that no one has changed her incontinence brief and she had a bowel movement and was unable to put the bed rail down by herself. "
On at 6:40 AM Resident #45 stated " I have been reported it since four in the morning, but night shift just wanted to sleep. "

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On at 6:42 AM interview with Resident #10 told to Day Shift ' s Supervisor " You can solve the problem in 10 minutes, you just need to bring me in the ."
On at 6:42 AM observed Staff X walk into Resident #10's , and stated " Yes, Resident #10 told me, but I am only one. "
On at 6:46 AM observed that the area in front of the West Nurse ' s station smelled like .
On at 1:10 PM observed that between # and #413 there was a strong smell. In an interview on at 9:07 AM Staff A2 revealed that she worked in activities and in the kitchen and spoke only Spanish.

On at 9:24 A.M. observed that activities were being conducted in Spanish in the West Dining #. Resident #54 stated " I just speak English " and confirmed having problems with the language. Resident #31 was observed sitting in a chair at one of the corner in West Dining # with eyes closed.

In an interview on at 9:30 AM Staff Y confirmed that Resident #54 and Resident #31 were English speakers.

During an interview on at 10:41 AM Resident # 18 stated "I ' m living here for 1 year and 6 months. My will speak for me. I ' m from England and I do not understand Spanish a lot. My helps me with the translation. I have a very hard time communicating with staff because they do not speak English. We need people to communicate in case of emergency."
During an interview on / at 10:55 AM Resident# 19 stated "I ' m living here for 2 years, I went to the administration to complain about the language barrier and I did not have any result . We have language barrier here. I have to help my with translation. I speak English and Spanish but we really need a person that can communicate with residents. We need help here. We need a change in here".
On resident #24 interviewed stated: " I have language communication barrier because Staff does not speak English. They need more staff that can communicate with residents"
Class III

0052 Medication - Assistance with Self-Admin

Based on observation and record review, the Assisted Living Facility failed to follow procedures identified in rule and statute while providing assistance with self-administration of medication to three of 60 sampled residents (Residents #46, 52 and 53).

Findings:

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Observation on at 9:02 AM revealed that Staff A1 assisted Resident#52 with medicines by putting pills in a cup, passing it to Resident #52 with a cup of water, removing gloves, and observing Resident #52 take the medicines, then initialing the Medication Observation Record (MOR). Staff A1, did not wash her hands or use hand sanitizer.

Observation on at 9:20 AM revealed that Staff A1 assisted Resident #53 with self-administration of medication scheduled at 9 AM. Staff A1 touched the trash can with gloved hands, removed gloves and put on new gloves but did not wash her hands or use hand sanitizer. Staff A1 then read medicines ' labels to the resident, and initialed MORs after the resident finished. Staff A1 removed the gloves but did not wash her hands or use hand sanitizer.

Observation on at 12:03 PM revealed that Staff A1 assisted Resident #46 in # with self-administration of medication. Staff A1 washed her hands, opened the medication card cart and took out three packages, verified them with the MORs, placed two tablets and one capsule in a disposable medication cup and handed it with a cup of water to Resident #46 while stating " here are your noon medicines. " Staff A1 observed that Resident #46 swallow the medicines and initialed the MORs.

A review of the MORs and reconciliation with the medicine packages for Resident #46 revealed that medicines were 25 mg (to treat high) one tablet by mouth three times a day, 25 mg (to treat motion sickness and), 100 mg (treat and pain caused by), they were scheduled at 7 AM, 12 PM and 4 PM.

Class III

0079 Staffing Standards - Levels

Based on observation, record review and interview the facility failed to provide sufficient staffing to meet scheduled and unscheduled resident needs and to ensure care and supervision for 20 out of 60 sampled residents (Res #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #18, #21, #24, #25, #27, #30, #39, #40). As a result of this inadequate staffing, Resident #21 choked during lunch and became , resulting in hospitalization and transfer to a rehabilitation facility. Eleven hospice residents (Residents 1-11) were unsupervised by staff when Resident # 6 and cut her head. Several residents who needed assistance with toileting were found with adult briefs filled with or feces, which had been unchanged for several hours.

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Findings:

A review of the facility's internal incident reports showed that Resident #21 choked during lunch on . The resident stopped breathing and became . Though the record reflect that the resident had a heartbeat, was initiated and the resident was transported to the hospital by Emergency Medical Services.
On at 9:53 AM, Staff G stated that on the day of the incident with Resident #21, she was working alone in South Dining #2. She further stated that there were 35 residents in that dining , and it was too much."

On at 11:06 A.M., observed Resident #6 standing up from her chair unassisted, and walking 3 or 4 steps. The resident then tried to sit, however no chair was behind her and she in sitting position on the floor trying to hold on to her wheelchair. Resident #6 hit her head on the wheelchair's armrest, and the cut began to .
On at 10:55 AM Staff A revealed that residents in # constantly stand and have risk of .

On at 11:00 AM, Resident #27's daughter revealed that early in the year, in , her mother was dropped on the floor by staff, broke her forehead and went to the hospital. She further stated, "there was less staff on the weekend, I have reported to Administrators and Supervisors. Last Saturday my mom did not eat and no one fed her."

On at 11:58 AM Staff A revealed that caregivers have told the Administrator about families' complaints about short staff on weekends, and the Administrator passed those concerns on to the facility's owners. Staff A stated that the facility's owners' response was that new employees would be hired, but nothing had happened yet. Staff A further stated that "Resident #27's daughter placed a complaint today ( ) but the facility has not started the investigation yet."

On at 8:05 a.m. Observed Staff Y serving breakfast to 31 residents. Staff stated another Staff was arriving at 8:00 a.m. At 8:25 a.m. Staff Y was still alone with residents in the dining .

On at approximately 8:06 a.m. Resident #7 was observed sitting on a couch. Staff Y stated that she keeps Resident #7 sitting on the couch while she is serving breakfast to other residents, She further stated that she was preventing Resident #7 from falling and because was alone, she could not take care special care of the resident. Staff Y said " When I finish serving all breakfasts I transfer resident #7 to the dining table and assist the resident to take breakfast."

On , at 10:15 AM, Resident # 30 stated, "staff is very slow because we do not have staff. If I

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need help I yell and staff takes time to come here. At some point I am neglected because I need to do things I cannot do and I need assistance with that. Staff is tired, they need help."

On / at 10:41 am, Resident #18 stated "we do not have administration here for more than 3 months. We do not have staff at night time. We need more staff at his facility to help us."

On at 6:16 AM Staff J (South Wing) stated, "my shift is from 10:30 p.m. till 7:00 a.m., every hour we have a rounds sheet and we check every hour. If someone needs help, the resident will shout for us. There are no call lights, there are no telephones. I can hear residents shouting, and I can identify the voice of the resident. The residents on this side are more independent and can do more on their own."

On at 6:20 AM Staff Q stated, "my shift is also from 10:30 PM-7:00 AM, I also do rounds every hour, and we have a round sheet. If the resident needs assistance, they can call for us and we hear them say 'help', we help them."

On at 8:47 AM Resident #25 stated, "I have been here for 1 year. One day I needed help to have my adult brief changed because I had done number one and number two, and the staff told me that they had to go to a meeting and could not help me. They left me for two hours in my dirty adult brief."

On at 7:01 AM Resident #24 stated, "I have been here for 10 months, I suffer from chronic pain. There is not enough staff sometimes to help. At night I have been awake watching TV from 11-2 AM, and I have not seen the staff make any rounds. Once in a blue moon, I ' ll hear them call my name. In my opinion if someone has a or a at night, there would not be anyone to help them."

On at 7:34 AM, observed Resident #40 sitting in a wheelchair in the dining , attempting to get out of wheelchair, repeatedly standing up and sitting back down. The wheelchair rolled backwards. No staff was present to assist the resident.
On at 7:34 AM Observed Resident #39 putting plastic nylon in his mouth. No staff was present to assist the resident.
On at 7:34 AM Observed 15 residents in dining # (left side), 13 in wheelchairs. There was no staff present to supervise the residents.

On at 11:00 AM interview with Staff A revealed " You are right, we need more employees. "
On at 1:26 PM Staff U said, " I have been here for 2 years, we have very little staff, we are one staff assigned to 15 residents. That is a lot, Resident #5 is at risk of choking. Many residents need

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	AL11968608	10/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDIAN GARDENS ASSISTED LIVING FACILITY	17250 SW 137 AVENUE MIAMI, FL 33177

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

all types of assistance. I have to help two residents with eating. But we are short staffed. "

A review of the records for Residents #1-11 and Residents #21 and 27 showed:
Resident #1's health assessment (AHCA form 1823) dated had Diagnoses ( ) of ( ), and Resident needed assistance with all activities of daily living (ADLs). The Resident's Hospice Interdisciplinary (ID) plan of care review dated revealed resident had , and alteration at risk.
Resident #2's health assessment (AHCA form 1823) dated had diagnoses ( ) of ( ), and . Resident needed assistance with all ADL ' s. The Resident's Hospice (ID) plan of care dated / revealed that the resident was at risk of .
Resident #3's health assessment (AHCA form 1823) dated had diagnoses ( ) of ( ), ( ), II, . The resident needed assistance with ambulation, bathing, dressing, self-care, toileting and transferring. The hospice interdisciplinary (ID) plan of care dated revealed resident was chair and bed bound. The treatment goal was to not experience injury, and to remain safe.
Resident #4 ' s health assessment (AHCA form 1823) dated had diagnoses ( ) of ( ), ' s . Further review showed that Resident #4 needed assistance with all ADL. The resident's hospice interdisciplinary (ID) plan of care dated revealed that the resident needed assistance with ADL and potential for injury.
Resident #5's health assessment (AHCA form 1823) dated had diagnoses ( ) of ' s, II, ( ), ( ). Resident #5 needed supervision with ambulation, eating, toileting, transferring and assistance with bathing, dressing, and self- care. The hospice interdisciplinary (ID) plan of care dated revealed that Resident #5 needed assistance with activities such as transfer to prevent injuries.
Resident #6 ' s health assessment (AHCA form 1823) dated had diagnoses ( ) of ( ), . Further review showed that that resident needed assistance with ambulation, toileting, transferring and assistance with bathing, dressing and self-care. The resident needed precautions.
Resident #7's health assessment (AHCA form 1823) dated had diagnoses ( ): Hydrocephaly (idiopathic), S/P VP ', ( ), , . The resident needed assistance with ambulation, bathing, dressing, self-care, toileting, and supervision with eating and transferring. Resident #7 's records showed that she was under precautions.
Resident #8's health assessment (AHCA form 1823) dated had diagnoses ( ): ( ), ( ), . Resident #8 needed supervision with bathing, dressing, self-care and toileting.
Resident #9's health assessment (AHCA form 1823) dated had diagnoses ( ):

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( ), ( ), chronic ( ), II.
Resident #9 needed supervision eating, self-care, toileting and transferring.
Resident #10's health assessment (AHCA form 1823) dated had diagnoses ( ) of ( ), ( ), Decreased memory, under nutrition and general decline. Resident #10 needed assistance with ambulating, bathing, dressing, self-care, transferring and toileting and self-administration of medications. Further review showed that under "nursing /treatment/ service requirements", "hospice service" was needed. Continued review showed that there was a prescription from a doctor for Resident #10 / for the resident to receive hospice care. There was no documentation that Resident #10 was receiving hospice care.
Resident #11's health assessment (AHCA form 1823) dated had diagnoses ( ): Parkinson's ( ), . Resident #11 needed assistance with ambulation, bathing, dressing, self-care, toileting and transferring.

Resident #21's health assessment (AHCA form 1823) dated showed diagnoses of , and . He needed assistance with ambulation.

Resident #27's health assessment (AHCA form 1823) dated showed diagnoses of ( ), , and . The resident was alert and oriented X2, and she needed assistance with ambulation, bathing and dressing.

Class III

0081 Training - Staff In-Service

Based on observation, record review and interview, the facility did not ensure that 1 out of 21 sampled staff that prepares and serves food to residents has the 1- hour -in -service training in safe food handling practices (Staff M). The facility failed provide training in assistance with activities of daily living (ADL) training with in 30 days of hire for two staff of 21 sampled staff (G and J).
Findings:
Record review showed that Staff G, hired on , did not receive the ADL training within 30 days of hire. Staff J (hired on /) did not receive ADL's training.
On at 12:45 PM Observed staff M, distributing food trays to residents in .
On at 2:56 pm Human resources Staff stated during interview " staff does carry the food to the resident and they give the food tray to residents or give the plate cover with a metallic top and place it to the resident. "
During an interview on at 2:57 Staff , resources (HR) reviewed staff G and J's records and acknowledged they did not have the ADL training.
Class III.

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SUMMARY STATEMENT OF DEFICIENCIES
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0093 Food Service - Dietary Standards

Based on observation, record review and interview the facility failed to ensure that 1 out of 21 sampled staff that prepares and serves food to residents, have the 1- hour -in -service training in safe food handling practices (Staff M).
Findings:
On at 12:45 PM Observed staff M, distributing food trays to residents in .
Record review of employee ' s M file did not have documentation of the 1-hour - in-service training in safe food handling practices.
On at 2:56 pm Staff in Human resources said " staff does carry the food to the residents and they give the food tray to residents or give the plate cover with a metallic top and place it to the residents. "

Class III

0162 Records - Resident

Based on observation, record review and interview the facility failed to follow physicians' orders for 1 out of 60 sample residents (Resident #10), and failed to have an interdisciplinary plan of care for one of 60 sampled residents (Resident #59).

Findings:

On at 11:05 a.m. during a facility tour, Resident #10 was observed in . No staff was present.

A review of Resident #10's health assessment (AHCA Form 1823 dated), , showed a Diagnosis of , , , Decreased Memory, General decline, under nutrition. The assessment showed, resident needed assistance with all ADLs and self administration of medications, resident could eat independently. Nursing /treatment/ service requirement, hospice care was prescribed. Further record review showed, the facility had no Hospice records verifying resident #10's admission to Hospice.

On at 2:25 p.m. the Administrator and Nursing Supervisor stated Resident #10 was not ambulatory. They acknowledged that the resident had a written Doctor's order to be admitted to Hospice in the health assessment dated / but said that resident is not admitted to Hospice, yet, by mistake.

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A review of the resident's record record revealed that Resident #59 received hospice services.
Review of hospice record for Resident #59 revealed the interdisciplinary plan of care was blank. There was a form named Proposed Visit Frequency completed by hospice staff on .
In an interview on at 2:20 PM Staff F stated regarding Resident #59, "It could not be possible, not having resident's Care Plan." Staff F called the hospice nurse who stated she was going to fax the plan immediately.

Class III

0165 Risk Mgmt & QA: Adverse Incident Report

Based on observation, record review and interview the facility failed to report 3 out of 3 incidents to AHCA (Residents #6, #7 and #21), when residents condition required them to be transported to a unit providing more acute care due to the incident, rather than the resident ' s condition before the incident .

Findings:

On Resident #6 was observed in with 4 stitches in her forehead.
On 09./ the facility Administrator and Supervisor (Staff Z) stated that Resident #7 in / and was sent to the hospital for evaluation on the same date.
Hospital Discharge record review showed: Resident #7 was admitted into hospital on at 12:02 Hospital Summary stated resident arrived to Emergency Department with a 5 cm laceration across forehead and no loss of was negative for any acute intracraneal processes but showed a minimal bone . Plastic surgery was consulted and no surgery was required. Discharge Summary Report review: Diagnoses: post nasal bone . Resident was Discharged on .
Resident #21 record review showed resident was admitted to facility on / and discharged on / . Resident #21 transfer out form dated showed a Broncho . Resident was transferred to the hospital, via rescue at 1:30 Pm. Observation log dated showed "the nurse was called to the dining area for an emergency with Resident #21 upon arrival noted the Resident did not respond to the procedure with the other nurse to give to the Patient after getting help from an employee to call rescue, remained receiving until paramedics arrived. The Patient left the facility with rescue at 1:30 PM".
Facility incident report log showed the facility filed internal incident report showing residents #6 and #7 in facility. Both residents had head injuries. Resident # 7 was transported to hospital and showed resident #21 was transferred to the hospital after a Broncho- .
A review of facility records and the incident report database showed that the facility failed to send a 24

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hour incident report to AHCA for resident #6, #7 and # 21.
On [redacted] at 01:55 p.m. the facility administrator said residents #6 and #7 [redacted] with injuries in facility, and resident #21 had Broncho-[redacted]. She further stated that residents #7 and #21 were transported to the hospital, after incidents. The Administrator acknowledged the facility failed to sent a 24 hour incident report to AHCA for residents #7 and #21.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

October _, _

Administrator
Floridian Gardens Assisted Living Facility
17250 Sw 137 Avenue
Miami, FL 33177

RE: CCR #2016010153

Dear Administrator:

This letter reports the findings of a complaint state licensure survey that was conducted on October , 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 November , .** 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 2016010153
XG90

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