RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016
AMENDED

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

Dear Administrator:

This letter reports the findings of a revisit survey conducted on 22 through , 2016 by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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. Should you have any questions please call this office at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure

88T7

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968608	R 12/01/2016

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)

0000 - Initial Comments

A Complaint Revisit Survey (CCR2016010153) was conducted from 11/22/16 until 12/01/16. Floridian Gardens with Limited Mental Health component, license # 12484 had the following deficiencies found at the time of the survey:

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review, interviews and observation, the Assisted Living Facility Failed to have accurate health assessment for 6 (#61, #62, #65, #67, #50, #20) out of 74 sampled residents.

Findings included:
A review of Resident #61's file revealed resident was . Health assessment (AHCA form 1823) completed on by physician showed medical history and diagnoses: Parkinson , ( ), ( ), . Resident was independent for ambulation, dressing, bathing, eating, toileting and transferring but needed supervision for self-care.
A review of facility's internal incident report completed on / at 9:30 PM revealed that Resident #61 between the toilet and the shower in the .
A review of Resident #61's hospital discharge summary revealed he went to the hospital on and the diagnosis was: " (on) (from) unspecified stairs and steps-with mild closed head and left hip ."
An interview on / at 2:27 PM the Resident #63 who was Resident #61's wife revealed that Resident #61 cannot walk and has multiple times (approximately 3).
An interview on / at 2:28 the Resident #61 revealed he cannot walk and has multiple times (approximately 3). Further interview at 2:32 PM the resident revealed that he needed assistance for transferring, toileting, self-care but staff had to bath him.
An interview on / at 2:29 PM Resident #63 stated "My husband in the ."
Observation on / / at 2:32 PM revealed that Resident #61 needed assistance with transfer and ambulation at least.
A review of Resident #62's file revealed resident was . Health Assessment (AHCA form 1823) completed on by physician showed medical history and diagnoses: , , radical , , , oral . Physical or sensory limitations: patient is ambulatory with assistance. Activities of daily living showed: independent for ambulation and eating, supervision for self-care, toileting and transferring, and assistance for bathing and dressing.
A review of facility's internal incident report completed on (Wednesday) at 6:00 PM revealed that resident was using her walker; she lost her balance, falling, and hitting her head against the floor,

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Resident #62 send to the hospital.
An interview on / 2:47 PM Resident #62's daughter-in-law revealed that her mother-in-law has twice during the night. Staff kept her clean. She used a rolling walker. They bath her.
A review of Resident #65's file revealed resident was 68 years. Health Assessment (AHCA form 1823) completed on / / by physician showed medical history and diagnosed: , , , , DMII, , , ( ), , . Activities of daily living: independent for ambulation, bathing, dressing, eating, toileting, and transferring, and supervision on self-care.
A review of facility's internal incident report revealed that Resident #65 on / (Tuesday) at 2:50 AM found during round in the floor. An interview on / at 2:53 PM the Resident #65 stated "I can bathe and dress on my own but my hands and legs get very weak. I had a about a week ago, right here on the floor. I have to use my walker because my legs and arms get limp and weak."
A review of Resident #67's file revealed resident was . Health assessment (AHCA form 1823) completed on by physician showed medical history and diagnosed with and Parkinson . Activities of daily living, resident #67 was independent for ambulation, eating, toileting, and transferring but needed supervision for bathing, dressing, and self-care. Resident #67 had precautions. A review of facility's internal incident report revealed that Resident #67 on (Wednesday) at 2 PM while walking alone, slipped and .
A review of facility's internal incident report revealed that Resident #67 was found in the floor of the at 8:35 PM by 's family member. Resident #67 had to face (nose). Resident #67 was sent to the hospital. An interview on / at 2:19 PM Resident #67 revealed that resident ambulates on her own; she stated she because the bed is too high. The she had before used to help her, she stated she got up to the and .
Observation on / / at 2:23 PM revealed that Resident #67 went alone in the the walker.
A review of Resident #50's file revealed resident was . Health assessment (AHCA form 1823) completed on showed medical history and diagnoses: normal , , generalized , . Physical or sensory limitations: difficulty walking. Special precautions: precautions. No identified as under hospice services in health assessment. Activities of daily living needed assistance for all (ambulation, bathing, dressing, eating, self-care, toileting, and transferring). The resident is receiving hospice care. Review of Resident #50's hospice nursing assessment completed on / / revealed reposition every 2 hours and as needed. A review of facility's internal incident report completed on / (Friday) at 10 AM revealed that Resident #50 has not been out of bed for three days. An interview on / at 8:38 AM during telephone interview the Administrator revealed that Resident #50 was not in continuous care with hospice. The facility staff was responsible for taking care of hospice residents and repositioning after hospice staff left the facility.
A review of Resident #25's file revealed resident was . Health Assessment (AHCA form

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1823) completed on 02/02/16 by physician showed medical history and diagnoses: toxicity, , DMII, diastolic chronic failure, status post left , . Physical or sensory limitations: unsteady gait. Special precautions: precautions. Resident needed assistance for ambulation, bathing, dressing, self-care, toileting, and transferring but supervision for eating. Special diet instructions: calorie controlled no added salt, mechanical soft, and no concentrated sweet.
A review of Resident #20's file revealed resident was . Health Assessment (AHCA form 1823) completed on by physician and showed medical history and diagnosed with advanced , history of previous , acute . Resident #20 needed assistance with all activities of daily living (ambulation, bathing, dressing, eating, self-care, toileting and transferring). Required 24 hour nursing or care. An interview on / at 2:06 PM the Administrator revealed that Resident #20 did not need 24 hour nursing or care.
Uncorrected
Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, record review and interview, the facility failed to provide care and services appropriated to the needs of the residents. The facility failed to offer daily observations and personal supervision to prevent resident and to prevent resident's from being abused for 14 out of 74 sampled residents (#20, 25, 50, 51, 54, 59, 61, 62, 64, 65, 66, 67, 72, & 73).
Findings included:

A)
1) A review of Resident #61's file revealed the resident was . Health assessment (AHCA form 1823) completed on by the physician showed the medical history and diagnoses: Parkinson , , , ( ), ( ), and . The resident was independent for ambulation, dressing, bathing, eating, toileting and transferring, but needed supervision for self-care. A review of the facility's internal incident report completed on /16 at 9:30 PM revealed, the Resident #61 between the toilet and the shower in the .
A review of Resident #61's hospital discharge summary revealed he went to the hospital on and the diagnosis was: " (on) (from) unspecified stairs and steps-with mild closed head and left hip ."
Interview on / at 2:27 PM with Resident #63 who was Resident #61's wife revealed, Resident #61 can't walk and has multiple times (approximately 3) and when he , his wife has to scream or go out of the , leaving him unattended looking for help.
Interview on / at 2:28 PM with Resident #61 revealed, he can't walk and has multiple

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times (approximately 3) and when he , his wife has to scream or go out of the room leaving him unattended looking for help. Further interview at 2:32 PM with the resident revealed, he needs assistance for transferring, toileting, and self-care, but staff had to bathe him.
During interview on / at 2:29 PM Resident #63 stated, "There are no nurses here at night. We do not get help. There is no way to call for help, there is no phone here. My husband in the I went to call the staff."
Observation on / / at 2:32 PM revealed, Resident #61 needs assistance with transfer and ambulation. Resident #61 sat in a wheelchair. Resident #61 had a half-bed rail attached to his bed and the prevention boots were at the top of the bed.
Interview on / at 2:33 PM with Resident #61 revealed, he used the bed rail and the boots when in bed.
Interview on / at 3:20 PM with the Administrator revealed, Resident #61 did not have a doctor's order for the bed rail or for the prevention boots.
2) A review of Resident #62's file revealed the resident was . The Health Assessment (AHCA form 1823) completed on / by the physician showed the medical history and diagnoses: , , , radical , , , ( ), and . The physical or sensory limitation includeds: patient is ambulatory with assistance. Activities of daily living showed: independent for ambulation and eating, supervision for self-care, toileting and transferring, and assistance for bathing and dressing.
A review of the facility's internal incident report completed on at 6:00 PM revealed, the resident was using her walker; she lost her balance, , and hit her head against the floor, Resident #62 was sent to the hospital.
A review of the facility's internal incident report completed on at 9:50 PM revealed, Resident #62 had lacerations and and was sent to the hospital.
Review of Resident #62's progress note completed by administration revealed, Resident #62's advised staff, the resident while trying to get out of bed. Staff found Resident #62 with a laceration to the right forehead. Resident #62 was . Resident #62 had a soft tissue hematoma to the right side of scalp.
Review of Resident #62's hospital record revealed, the resident was treated for , of the right joint, on the same level by slipping, single laceration to the forehead, and a single with soft tissue hematoma to the forehead. The photo in the record showed four staples in the forehead.
Observation on / / at 2:47 PM revealed, Resident #62 had a skin discoloration to the left cheek. The resident's cheek was greenish/dark purple in color.
Interview on / at 2:47 PM with Resident #62's daughter-in-law revealed, her mother-in-law has twice during the night and the resident used a rolling walker.
3) A review of Resident #54's file revealed, the resident was . The Health Assessment

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(AHCA form 1823) completed on showed the medical history and diagnoses as: Type II (DMII), over reactive , incontinence. The physical or sensory limitations included: unstable gait. Activities of daily living showed assistance with ambulation, bathing and dressing, supervision for self-care, toileting, and transferring, and independent for eating.
A review of the facility's internal incident report completed on at 3:50 AM revealed, Resident #54 was found sitting in the skin broken on the arms and on the left leg, and "hit in the face" according to the chart. The resident #54 was sent to the hospital.
4) A review of Resident #65's file revealed, the resident was 68 years. The Health Assessment (AHCA form 1823) completed on / by the physician showed the medical history and diagnoses as: , , , , , , DMII, , , ( ), , and .
The activities of daily living included: independent for ambulation, bathing, dressing, eating, toileting, transferring, and supervision for self-care.
A review of the facility's internal incident report revealed, Resident #65 on / / at 2:50 AM, the resident was found on the floor during rounds.
During interview on / at 2:53 PM Resident #65 stated, "I can bathe and dress on my own but my hands and legs get very weak. I had a about a week ago, right here on the floor. I hit my head on the night stand and landed on the floor. They are supposed to make rounds but I don't see them during the night. I have to use my walker because my legs and arms get limp and weak. I have had about 3 or 4 in the past month. To get help, I would have to yell out, the day I had the my tried to help me and she called the staff."
5) A review of Resident #66's file revealed, the resident was 68 years. The Health Assessment (AHCA form 1823) completed on / by the physician and showed the residents medical history and diagnoses included: , , , , , , , and unspecified . The physical or sensory limitations included: ambulatory with assistance or device, wheelchair. Activities of daily living: needed assistance with ambulation, bathing, dressing, self-care, toileting and transferring but independent for eating.
A review of the facility' s internal incident report revealed that Resident #66 on at 11:00 PM from the wheelchair during an attempt to turn the wheelchair.
6) A review of Resident #67's file revealed, the resident was . The Health assessment (AHCA form 1823) completed on by the physician showed the medical history and diagnoses included and Parkinson . Activities of daily living: resident #67 was independent for ambulation, eating, toileting, and transferring but needed supervision for bathing, dressing, and self-care. Resident #67 had precautions.
A review of the facility's internal incident report revealed, on at 2:00 PM while walking alone, Resident #67 slipped and . She complained of shoulder pain. Resident #67 went to the hospital and was recommended to use a sling.
A review of the facility's internal incident report revealed, Resident #67 was found on the floor of the

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bathroom on 07/07/16 at 8:35 PM by the roommate's family member. Resident #67 had a to the face (nose). Resident #67 was sent to the hospital.
During interview on / /2016 at 2:19 PM Resident #67 revealed, the resident ambulates on her own. She reported, she because the bed was too high and her previous used to help her. She reported, she got up to the and .
Observation on / / at 2:23 PM revealed, Resident #67 went alone to the the walker.
7) A review of Resident #25's file revealed, the resident was . The Health Assessment (AHCA form 1823) completed on by the physician showed the medical history and diagnoses included: toxicity, , DMII, diastolic chronic failure, status post left , , , . Physical or sensory limitations included: unsteady gait. Special precautions: precautions. Resident needed assistance for ambulation, bathing, dressing, self-care, toileting, and transferring, but supervision for eating. Special diet instructions: calorie controlled no added salt, mechanical soft, and no concentrated sweets.
A review of the facility's internal incident report completed on 11/ at 2:10 AM revealed, the resident was found on the floor. Resident #25 was transferred to the hospital. The resident was seen on / at the hospital and had a single superficial laceration to the scalp, multiple superficial skin of the left upper arm and of the left , multiple with soft tissue hematoma to the forehead and left periorbital area, and gait abnormality-unsteadiness. The CT WO CON (Computed Tomography scan without Contrast) conducted on / revealed, a left frontal scalp hematoma without evidence of acute abnormality.
A review of the facility's internal incident report completed for Resident #25 on at 9:30 PM in the descriptions section documented, " advised that the resident was (see back)," however there was no back to the form. Additionally, the document included, "Emergency treatment given: ice/ ambulance."
A review of the facility's internal incident report completed for Resident #25 on / / at 5:45 AM in the descriptions section documented, "see attached document." Emergency treatment given: staff assist the resident in getting up and offered ICE and ER transportation.
Observation on / at 8:15 AM revealed, Resident #25 transferred with staff assistance to the table. The resident had a purple hematoma to the forehead and left periorbital area. He appeared irritable and stated, "I here over 15 days ago in my , I get and I . I went to the hospital."
Interview on / at 8:28 AM with the Administrator revealed, staff reported Resident #25 wanted to change from one bed to another bed and he did it by himself and he . The administrator stated, he went to the hospital.
8) A review of Resident #20's file revealed, the resident was , . The Health Assessment (AHCA form 1823) completed on / by the physician and showed the medical history and diagnoses included advanced , history of previous , and acute

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. Resident #20 needed assistance with all activities of daily living to include ambulation, bathing, dressing, eating, self-care, toileting and transferring. The resident required 24 hour nursing or care.
A review of the facility's internal incident report showed on / at 1:40 AM, found Resident #20 on the floor with redness on the right eye and right side of the head. Resident #20 was transferred to hospital.
Interview on / at 2:06 PM wit the Administrator revealed, Resident #20 did not need 24 hour nursing or care.
9) A review of Resident #64's file revealed, the resident's diagnoses were , and .
A review of the facility's internal incident report showed on 11/ at 12:30 AM, Resident #64's husband informed the caregiver that his wife was on the floor. The resident complained about pain, but didn't go to the hospital.
Interview on / at 2:03 PM with the Administrator revealed, the facility's precautions were to supervise or assist with activities of daily living.
Interview on / at 10:20 AM via telephone, the Administrator revealed the facility did not have any policies and procedures for or precautions. The administrator reported, they are creating them now and are going to implement them. A review of the facility's policy created soon after the interview documented, if a resident had a , staff would provide or arrange for necessary emergency care and will follow up with necessary plan updates.
A review of the staff schedule showed a total of 539 staff hours for all weeks in . The facility 's census was between 145 and 152 (different numbers were provided by the staff), which would have required 623 staff hours. Also, only 5 staff have routinely been assigned on the overnight shift (between 11:00 pm and 7:00 am), which is when many of the have occurred.
Observation on / / at 6:00 am showed there were 5 staff on duty (3 on the west wing, 2 on the south wing where there are residents who need more assistance, and where the was alleged to be occurring). The total census was 145 residents.
A review of the "rounding tool" used by staff to record resident whereabouts each hour revealed, on / at 8:00 AM noobody knew where Resident #20 was. On / at 2:00 PM, the rounding tool was not completed in the 200's, 300's, and 400's . On / at 3:30 PM nobody knew where Residents #68, #69, #70 and #30 were located.

B) In an interview on / at 6:39 AM, Resident #71 stated, "I'm , but I know what is right or what is wrong, but something is wrong in here. We have a male resident that one lady that can not talk or do anything, she is totally lost. He kisses her, he touches her. I called her sister and I told her that she needed to care about her because Resident #72 likes to her sister." Resident #71 stood in front of the photograph posted on the wall and stated, "this is the resident and her sister. Staff know

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that Resident #72 liked to touch women and they do not do anything. He does not have specific time he do it. "

In an interview on /__ at 8:40 A.M. Resident #37 stated, she heard resident #72 touches Resident #73 and kisses her. I saw her that she went to the bed with a man that took her by her hands to his , (She did not provide the resident's name). She stated, "caregivers know that." She stated, last Sunday we had only two staff working here, Caregivers A3 and Z and they got crazy because they needed to assist a lot of people. We are under staffed here.

In an interview on /__ at 9:06 AM Resident #74 stated, "we have Resident #72 that abuses Resident #73, he kissed her and touched her. Resident #73 is a type of person that will go with anyone that leads her by the hands. I'm not a doctor, but she is not mentally competent to know what's right or wrong. I pointed a few times to Resident #72 to stop kissing and touching her. I never get physical with him, but I did verbally. Staff knows that he likes to touch women, but the staff just separate them when they are together. I do not like to talk to the Administrator because she likes to drop the ball every time that I have a major concern...."

In an interview on /__ at 9:50 AM Resident #73's sister stated via phone, " I'm the sister not a daughter. I love my sister so much and go there every day in the afternoon to see her. I've been told that Resident #72 likes to kiss and touch my sister. This is something that's been going on for a while, over a year. I went to the old Administration and complained. I told the Administrator that something's going on and needs to stop. I went personally to Resident #72 and his mother's talk to him, I told him that I do not want him to touch or kiss my sister anymore. I confronted staff, I do not remember her name, she was on the defensive telling me that was impossible that a resident had been touching my sister. I talked to the new Administrator about a month ago and informed the same resident was continuing molesting my sister and other ladies." Resident #73's sister further stated, " Yes I know Resident #72 is that way; he does it also to Resident #3, he puts his hands under the blanket. Resident #72 did to this to other ladies that were seated in wheelchairs with blankets on their legs; he put his hands under and between their legs. I heard from residents that these continue."

Review of Resident #73's file revealed, the resident admission date was on / . The Health Assessment (AHCA 1823) dated showed diagnoses to include: , , , , , , ( ); Alert and Orient X 2 and forgetful at times. The resident was independent for ambulation, eating, toileting, and transferring but needed supervision with bathing, dressing, self-care. The Health assessment dated showed Diagnoses: , , confuse. Resident was independent with eating but needed supervision with ambulation, bathing, dressing, self-care, toileting, and transferring. The Residency Agreement dated showed the facility will assist with third party services, reporting , neglect and and every employee from the facility was required to report , neglect and to law enforcement and to the Florida Hotline.

Review of Resident #73's progress note from / until / showed that there was no

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documentation about the by another resident. There was also no documentation about the family concern or complaint in the resident's file.
A review of the facility's internal incident report completed on / / showed on / at 4:00 PM Resident #73's sister reported, Resident #72 sat close to her sister and she was scared that he can have a attitude with her sister. The facility informed Resident #73's sister that Resident #73 was the one that wanted to sit near to Resident #72. Caregiver Z1 who received the report immediately reported to the supervisor. Facility follow up to Resident #72 was done on / / by Caregiver B and it showed the Resident did not have any abnormal behavior. The Resident was told not to stay close to Resident #72 as a preventive measure.
In an interview on / at 11:17 AM, the Administrator revealed that Resident #73's sister informed her that residents told her that her sister has been touch by another male resident. The Facility's administrator stated, she informed staff responsible of the cameras to check them. She stated, "I do not remember when it happened but I made the report and we do have the incident report here. " She stated, staff responsible for the cameras checked the camera and nothing showed in there; the only thing that showed was both of them seated together. She stated, "I haven't seen the camera myself. They reviewed it for a certain time because the cameras were out of order for some period of time. She stated, Resident #73's sister reported the incident to the other administration. The administrator reported, "I went to ask the CNA's one by one in person and no one knew anything about the incident. I addressed the staff to observe Resident #73 that men can not sit next to her. I did not tell staff clearly the reason for privacy. "
In an interview on / at 12:54 PM, Caregiver A3 stated, "I'm working here for about 2 and 1/2 years and no incident has been reported to me. We do not sit Resident #73 near men, she have to be away from men because she pinch and touch them. The Administrator was informed about the incident that Resident #72 touched Resident #73 improperly and this is the reason that we are looking after her."
In an interview on / at 1:00 PM, Caregiver D1 stated, "I'm a CNA for the area of . I have been working here for 1 year and 4 months and my shift is 6:30 AM to 3:00 PM. I have not seen any incident with Resident #73, but her sister informed the resident has been touched and kissed by Resident #72. The facility administrator never notified the resident needed to be supervised."
Review of Resident #72's file revealed, the admission date was / . The Health assessment (AHCA from 1823) completed on showed diagnoses , , DMII, . The resident's or behavioral status was alert and oriented. Resident was independent with ambulation, eating, toileting and transferring and needed supervision with bathing, dressing and self-care.
In an interview on / at 4:17 PM, the Administrator stated, one action in place was to keep Resident #73 supervised all the time and the other action was to move Residents #72 and #73 to different wings, but both of the family members refused to move them to another area.

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In an interview on 11/28/16 at 1:00 PM Caregiver B revealed, the Administrator informed her that Resident#72 had an incident with Resident #73, but the Administrator did not tell the reason why both residents needed to be in total supervision or staff needed to report any inappropriate attitude between them. Caregiver B did the follow up of the incident and when she did it, she didn't have detailed information about the incident. She stated, "the incident was that Resident #72 was inappropriately touching Resident #73's legs but I did not see the incident with my eyes, I was informed by the administration."
In an interview on / at 1:03 PM, Resident #74 stated via the phone, "I do not count the time, I do not have track of that because I have to take care of my own things. The last time that happened was like a month ago, and he is a repeat offender."

C) On / at 5:50 AM observed in that Resident #59 was in wheelchair, observed the resident had a sign in her read, "Keep door Open." There was a odor in the hallway by the resident's .
Observation on / at 6:12 AM revealed, there was a strong smell in the hallway between 203, 204, 205 and 206.
Observation on / at 6:18 AM revealed, there was a odor in the south station area.
Observation on / at 9:19 AM revealed, Caregiver L was with 9 residents, most residents were in wheelchairs, or had wheelchairs next to them.
Interview on / at 9:19 AM with Caregiver M revealed these residents need a little more supervision.
Observation on / at 9:18 AM revealed, Residents #51 and #55 sat in wheelchairs in # . Resident #51 stated, "I received hospice care and they came here in the morning and change my adult brief and in the afternoon by facility staff. She stated, we do not have staff here, if I need a HHA (Home Health Aide) I have to transfer with my wheelchair to look for them. On the weekends we have only two staff here for a lot of people. "
D) A review of Resident #50's file revealed, the resident was , . The Health assessment (AHCA form 1823) completed on showed the medical history and diagnoses included: normal , , generalized , . Physical or sensory limitations: difficulty walking. Special precautions: precautions. No was identified under hospice services in the health assessment. Activities of daily living included, needed assistance for all ambulation, bathing, dressing, eating, self-care, toileting, and transferring. But, the resident was receiving hospice care.
Review of Resident #50's hospice nursing assessment completed on / / revealed, reposition every 2 hours and as needed.
A review of the facility's internal incident report completed on / at 10:00 AM revealed, Resident #50 had not been out of bed for three days. The caregiver wrote, the Resident did not get out of bed since Tuesday and was found during change time with red spots on the right thigh.

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Interview on 11/30/16 at 8:38 AM with the Administrator revealed, Resident #50 was not in continuous care with hospice. The facility staff was responsible for taking care of hospice residents and repositioning after hospice staff left the facility.

Class I

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, interview and record review, the facility failed to ensure each resident's right to live in a safe environment, free of and neglect. The facility failed to have a procedure for receiving and responding to resident or family complaints, and for residents to recommend changes to facility policies and procedures for four of 74 sampled residents (Residents # 8, 51, 73 and 74).
Findings included:

1) In an interview on / / at 6:39 AM, Resident #71 stated, "I'm , but I know what is right or what is wrong, but something is wrong in here. We have a male resident that one lady that can not talk or do anything, she is totally lost. He kisses her, he touches her. I called her sister and I told her that she needed to care about her because Resident #72 likes to her sister." Resident #71 stood in front of the photograph posted on the wall and stated, "this is the resident and her sister. Staff know that Resident #72 liked to touch women and they do not do anything. He does not have specific time he do it. "
In an interview on / at 8:40 A.M. Resident #37 stated, she heard resident #72 touches Resident #73 and kisses her. I saw her that she went to the bed with a man that took her by her hands to his , (She did not provide the resident's name). She stated, "caregivers know that." She stated, last Sunday we had only two staff working here, Caregivers A3 and Z and they got crazy because they needed to assist a lot of people. We are under staffed here.
In an interview on / at 9:06 AM Resident #74 stated, "we have Resident #72 that abuses Resident #73, he kissed her and touched her. Resident #73 is a type of person that will go with anyone that leads her by the hands. I'm not a doctor, but she is not mentally competent to know what's right or wrong. I pointed a few times to Resident #72 to stop kissing and touching her. I never get physical with him, but I did verbally. Staff knows that he likes to touch women, but the staff just separate them when they are together. I do not like to talk to the Administrator because she likes to drop the ball every time that I have a major concern...."
In an interview on / at 9:50 AM Resident #73's sister stated via phone, " I'm the sister not a daughter. I love my sister so much and go there every day in the afternoon to see her. I've been told that Resident #72 likes to kiss and touch my sister. This is something that's been going on for a while, over a year. I went to the old Administration and complained. I told the Administrator that something's going on and needs to stop. I went personally to Resident #72 and his mother's talk to him, I told him that

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I do not want him to touch or kiss my sister anymore. I confronted staff, I do not remember her name, she was on the defensive telling me that was impossible that a resident had been touching my sister. I talked to the new Administrator about a month ago and informed the same resident was continuing molesting my sister and other ladies." Resident #73's sister further stated, " Yes I know Resident #72 is that way; he does it also to Resident #3, he puts his hands under the blanket. Resident #72 did to this to other ladies that were seated in wheelchairs with blankets on their legs; he put his hands under and between their legs. I heard from residents that these continue."

Review of Resident #73's file revealed, the resident admission date was on / . The Health Assessment (AHCA 1823) dated showed diagnoses to include: , , , , , , ( ); Alert and Orient X 2 and forgetful at times. The resident was independent for ambulation, eating, toileting, and transferring but needed supervision with bathing, dressing, self-care. The Health assessment dated / showed Diagnoses: , , , , confuse. Resident was independent with eating but needed supervision with ambulation, bathing, dressing, self-care, toileting, and transferring. The Residency Agreement dated / / showed the facility will assist with third party services, reporting , neglect and and every employee from the facility was required to report , neglect and to law enforcement and to the Florida Hotline.

Review of Resident #73's progress note from / until showed that there was no documentation about the by another resident. There was also no documentation about the family concern or complaint in the resident's file.

A review of the facility's internal incident report completed on / showed on / at 4:00 PM Resident #73's sister reported, Resident #72 sat close to her sister and she was scared that he can have a attitude with her sister. The facility informed Resident #73's sister that Resident #73 was the one that wanted to sit near to Resident #72. Caregiver Z1 who received the report immediately reported to the supervisor. Facility follow up to Resident #72 was done on / by Caregiver B and it showed the Resident did not have any abnormal behavior. The Resident was told not to stay close to Resident #72 as a preventive measure.

In an interview on 11/ at 11:17 AM, the Administrator revealed that Resident #73's sister informed her that residents told her that her sister has been touch by another male resident. The Facility's administrator stated, she informed staff responsible of the cameras to check them. She stated, "I do not remember when it happened but I made the report and we do have the incident report here. " She stated, staff responsible for the cameras checked the camera and nothing showed in there; the only thing that showed was both of them seated together. She stated, "I haven't seen the camera myself. They reviewed it for a certain time because the cameras were out of order for some period of time. She stated, Resident #73's sister reported the incident to the other administration. The administrator reported, "I went to ask the CNA's one by one in person and no one knew anything about the incident. I addressed the staff to observe Resident #73 that men can not sit next to her. I did not tell staff clearly

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the reason for privacy. "
In an interview on 11/22/2016 at 12:54 PM, Caregiver A3 stated, "I'm working here for about 2 and 1/2 years and no incident has been reported to me. We do not sit Resident #73 near men, she have to be away from men because she pinch and touch them. The Administrator was informed about the incident that Resident #72 touched Resident #73 improperly and this is the reason that we are looking after her."
In an interview on / at 1:00 PM, Caregiver D1 stated, "I'm a CNA for the area of . I have been working here for 1 year and 4 months and my shift is 6:30 AM to 3:00 PM. I have not seen any incident with Resident #73, but her sister informed the resident has been touched and kissed by Resident #72. The facility administrator never notified the resident needed to be supervised."
Review of Resident #72's file revealed, the admission date was . The Health assessment (AHCA from 1823) completed on showed diagnoses , DMII, . The resident's or behavioral status was alert and oriented. Resident was independent with ambulation, eating, toileting and transferring and needed supervision with bathing, dressing and self-care.
In an interview on / at 4:17 PM, the Administrator stated, one action in place was to keep Resident #73 supervised all the time and the other action was to move Residents #72 and #73 to different wings, but both of the family members refused to move them to another area.
In an interview on / at 1:00 PM Caregiver B revealed, the Administrator informed her that Resident#72 had an incident with Resident #73, but the Administrator did not tell the reason why both residents needed to be in total supervision or staff needed to report any inappropriate attitude between them. Caregiver B did the follow up of the incident and when she did it, she didn't have detailed information about the incident. She stated, "the incident was that Resident #72 was inappropriately touching Resident #73's legs but I did not see the incident with my eyes, I was informed by the administration."
In an interview on / at 1:03 PM, Resident #74 stated via the phone, "I do not count the time, I do not have track of that because I have to take care of my own things. The last time that happened was like a month ago, and he is a repeat offender."

2) During interview on / at 9:06 AM Resident #74 stated, " We have a major concern here about the language barrier, ... We have to deal with Spanish speakers only." He further stated, "for example I do not speak Spanish and for that reason I do everything by myself because it takes so much time to explain to them when I need something. I am trying to learn but this takes time. It is making it difficult for us; in case of emergency I don't know how they will understand me."
Observation on / at 1:13 PM revealed, in the West Wing in dining , observed four residents sitting at tables playing games. Observed the music was in Spanish, and staff were conducting activities in Spanish.

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On 11/28/2016 at 2:50 PM, observed staff giving residents snacks, cookies and tea. The music was in Spanish.
Observation on 11/28/2016 at 9:18 AM revealed that Residents #51 and #55 sat in wheelchairs in Room # 602. Resident #51 stated, "I received hospice care and they came here in the morning and change my adult brief and in the afternoon by facility staff. She stated, we do not have staff here, if I need a HHA (Home Health Aide) I have to transfer with my wheelchair to look for them. On the weekends, we have only two staff here for a lot of people."
3) Observation on / during facility tour at 6:12 a.m. revealed that Resident #1, resided in # and Resident # 8, lived in #
Observation on / at 6:12 AM revealed, there was a strong smell in the hallway between , 204, 205 and 206.
Observation on / at 6:18 AM revealed, there was a odor in the South station area.

Class I

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the Assisted Living Facility failed to keep medications locked at all times.
Findings included:
Observation on / / at 2:30 PM revealed that Resident #63 had in the bottom of the resident's night tablet a bottle of (upset stomach, and . It is also used to treat) and a bottle of (to treat and flu symptoms such as , sneezing and runny nose).
In an interview on / at 2:31 PM Resident #63 revealed that those were her medicines.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on record review and interview, the Assisted Living Facility failed to ensure that a doctor's order was in place before a nurse administered a medication for one out of 74 sampled residents (#61).

Findings included:

Review of Resident #61 ' s observation log completed on / revealed that it was completed on / by a nurse and nurse gave him (nurse did not document the dose) mg per oral at 1 PM and then again at 7 PM as per physician's orders. Nurse assessed the resident an hour after the medication was administered, and the resident was comfortable, did not report any side effects of the medication and pain was alleviated.

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Review of Resident #61's Medication Observation Record (MORs) for 2016 and 2016 revealed that there was no documentation for given on / at 1 PM and at 7 PM.
Review of Resident #61's record revealed that there was no doctor's order for .

In an interview on / at 10 AM the Registered Nurse B revealed that he was certain that he had the doctor's order in hand before giving the medications.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observation, record review and interview, the facility failed to meet the minimum staffing hour ratio and the the minimum staffing needed to ensure that residents obtained adequate supervision and assistance and care for their scheduled and unscheduled needs. This lack of staffing contributed to with injury and to occur in the facility, 15 out of 74 sampled residents (#20, 25, 37, 50, 51, 54, 59, 61,62, 64, 65, 66,67, 72, and 73).

Findings included:

1) A review of Resident #61's file revealed the resident was . Health assessment (AHCA form 1823) completed on by the physician showed the medical history and diagnoses: Parkinson , , , , ( ), ( ), and . The resident was independent for ambulation, dressing, bathing, eating, toileting and transferring, but needed supervision for self-care. A review of the facility's internal incident report completed on / at 9:30 PM revealed, the Resident #61 between the toilet and the shower in the .
A review of Resident #61's hospital discharge summary revealed he went to the hospital on / and the diagnosis was: " (on) (from) unspecified stairs and steps-with mild closed head and left hip ."
Interview on / at 2:27 PM with Resident #63 who was Resident #61's wife revealed, Resident #61 can't walk and has multiple times (approximately 3) and when he , his wife has to scream or go out of the , leaving him unattended looking for help.
Interview on / at 2:28 PM with Resident #61 revealed, he can't walk and has multiple times (approximately 3) and when he , his wife has to scream or go out of the him unattended looking for help. Further interview at 2:32 PM with the resident revealed, he needs assistance for transferring, toileting, and self-care, but staff had to bathe him.
During interview on / / at 2:29 PM Resident #63 stated, "There are no nurses here at night. We do

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not get help. There is no way to call for help, there is no phone here. My husband in the bathroom and I went to call the staff."
Observation on at 2:32 PM revealed, Resident #61 needs assistance with transfer and ambulation. Resident #61 sat in a wheelchair. Resident #61 had a half-bed rail attached to his bed and the prevention boots were at the top of the bed.
Interview on at 2:33 PM with Resident #61 revealed, he used the bed rail and the boots when in bed.
Interview on at 3:20 PM with the Administrator revealed, Resident #61 did not have a doctor's order for the bed rail or for the prevention boots.
2) A review of Resident #62's file revealed the resident was . The Health Assessment (AHCA form 1823) completed on by the physician showed the medical history and diagnoses: , , radical , , ( ), and . The physical or sensory limitation includeds: patient is ambulatory with assistance. Activities of daily living showed: independent for ambulation and eating, supervision for self-care, toileting and transferring, and assistance for bathing and dressing.
A review of the facility's internal incident report completed on at 6:00 PM revealed, the resident was using her walker; she lost her balance, , and hit her head against the floor, Resident #62 was sent to the hospital.
A review of the facility's internal incident report completed on at 9:50 PM revealed, Resident #62 had lacerations and and was sent to the hospital.
Review of Resident #62's progress note completed by administration revealed, Resident #62's advised staff, the resident while trying to get out of bed. Staff found Resident #62 with a laceration to the right forehead. Resident #62 was . Resident #62 had a soft tissue hematoma to the right side of scalp.
Review of Resident #62's hospital record revealed, the resident was treated for , of the right joint, on the same level by slipping, single laceration to the forehead, and a single with soft tissue hematoma to the forehead. The photo in the record showed four staples in the forehead.
Observation on at 2:47 PM revealed, Resident #62 had a skin discoloration to the left cheek. The resident's cheek was greenish/dark purple in color.
Interview on at 2:47 PM with Resident #62's daughter-in-law revealed, her mother-in-law has twice during the night and the resident used a rolling walker.
3) A review of Resident #54's file revealed, the resident was . The Health Assessment (AHCA form 1823) completed on showed the medical history and diagnoses as: Type II (DMII), over reactive , incontinence. The physical or sensory limitations included: unstable gait. Activities of daily living showed assistance with ambulation, bathing and dressing, supervision for self-care, toileting, and transferring, and independent for eating.

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A review of the facility's internal incident report completed on 10/13/16 at 3:50 AM revealed, Resident #54 was found sitting in the bathroom with skin broken on the arms and on the left leg, and "hit in the face" according to the chart. The resident #54 was sent to the hospital.

4) A review of Resident #65's file revealed, the resident was 68 years. The Health Assessment (AHCA form 1823) completed on / by the physician showed the medical history and diagnoses as: , DMII, , ( ), , and . The activities of daily living included: independent for ambulation, bathing, dressing, eating, toileting, transferring, and supervision for self-care.

A review of the facility's internal incident report revealed, Resident #65 on at 2:50 AM, the resident was found on the floor during rounds.

During interview on / at 2:53 PM Resident #65 stated, "I can bathe and dress on my own but my hands and legs get very weak. I had a about a week ago, right here on the floor. I hit my head on the night stand and landed on the floor. They are supposed to make rounds but I don't see them during the night. I have to use my walker because my legs and arms get limp and weak. I have had about 3 or 4 in the past month. To get help, I would have to yell out, the day I had the my tried to help me and she called the staff."

5) A review of Resident #66's file revealed, the resident was 68 years. The Health Assessment (AHCA form 1823) completed on by the physician and showed the residents medical history and diagnoses included: , , , , and unspecified . The physical or sensory limitations included: ambulatory with assistance or device, wheelchair. Activities of daily living: needed assistance with ambulation, bathing, dressing, self-care, toileting and transferring but independent for eating.

A review of the facility' s internal incident report revealed that Resident #66 on / at 11:00 PM from the wheelchair during an attempt to turn the wheelchair.

6) A review of Resident #67's file revealed, the resident was . The Health assessment (AHCA form 1823) completed on by the physician showed the medical history and diagnoses included and Parkinson . Activities of daily living: resident #67 was independent for ambulation, eating, toileting, and transferring but needed supervision for bathing, dressing, and self-care. Resident #67 had precautions.

A review of the facility's internal incident report revealed, on / at 2:00 PM while walking alone, Resident #67 slipped and . She complained of shoulder pain. Resident #67 went to the hospital and was recommended to use a sling.

A review of the facility's internal incident report revealed, Resident #67 was found on the floor of the at 8:35 PM by the 's family member. Resident #67 had a to the face (nose). Resident #67 was sent to the hospital.

During interview on / at 2:19 PM Resident #67 revealed, the resident ambulates on her own. She reported, she because the bed was too high and her previous used to help her. She

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reported, she got up to the bathroom alone and .
Observation on 11/28/16 at 2:23 PM revealed, Resident #67 went alone to the bathroom using the walker.
7) A review of Resident #25's file revealed, the resident was 88 years old. The Health Assessment (AHCA form 1823) completed on by the physician showed the medical history and diagnoses included: toxicity, , DMII, diastolic chronic failure, status post left , , , . Physical or sensory limitations included: unsteady gait. Special precautions: precautions. Resident needed assistance for ambulation, bathing, dressing, self-care, toileting, and transferring, but supervision for eating. Special diet instructions: calorie controlled no added salt, mechanical soft, and no concentrated sweets.
A review of the facility's internal incident report completed on 11/ / at 2:10 AM revealed, the resident was found on the floor. Resident #25 was transferred to the hospital. The resident was seen on / / at the hospital and had a single superficial laceration to the scalp, multiple superficial skin of the left upper arm and of the left , multiple with soft tissue hematoma to the forehead and left periorbital area, and gait abnormality-unsteadiness. The CT WO CON (Computed Tomography scan without Contrast) conducted on / revealed, a left frontal scalp hematoma without evidence of acute abnormality.
A review of the facility's internal incident report completed for Resident #25 on at 9:30 PM in the descriptions section documented, " advised that the resident was (see back)," however there was no back to the form. Additionally, the document included, "Emergency treatment given: ice/ ambulance."
A review of the facility's internal incident report completed for Resident #25 on at 5:45 AM in the descriptions section documented, "see attached document." Emergency treatment given: staff assist the resident in getting up and offered ICE and ER transportation.
Observation on / at 8:15 AM revealed, Resident #25 transferred with staff assistance to the table. The resident had a purple hematoma to the forehead and left periorbital area. He appeared irritable and stated, "I here over 15 days ago in my , I get and I . I went to the hospital."
Interview on / at 8:28 AM with the Administrator revealed, staff reported Resident #25 wanted to change from one bed to another bed and he did it by himself and he . The administrator stated, he went to the hospital.
8) A review of Resident #20's file revealed, the resident was . The Health Assessment (AHCA form 1823) completed on / by the physician and showed the medical history and diagnoses included advanced , history of previous , and acute . Resident #20 needed assistance with all activities of daily living to include ambulation, bathing, dressing, eating, self-care, toileting and transferring. The resident required 24 hour nursing or care.
A review of the facility's internal incident report showed on / at 1:40 AM, found Resident #20 on

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the floor with redness on the right eye and right side of the head. Resident #20 was transferred to hospital.
Interview on 11/28/16 at 2:06 PM wit the Administrator revealed, Resident #20 did not need 24 hour nursing or care.
9) A review of Resident #64's file revealed, the resident's diagnoses were , and .
A review of the facility's internal incident report showed on / at 12:30 AM, Resident #64's husband informed the caregiver that his wife was on the floor. The resident complained about pain, but didn't go to the hospital.
Interview on / at 2:03 PM with the Administrator revealed, the facility's precautions were to supervise or assist with activities of daily living.
Interview on / at 10:20 AM via telephone, the Administrator revealed the facility did not have any policies and procedures for or precautions. The administrator reported, they are creating them now and are going to implement them. A review of the facility's policy created soon after the interview documented, if a resident had a , staff would provide or arrange for necessary emergency care and will follow up with necessary plan updates.
A review of the staff schedule showed a total of 539 staff hours for all weeks in . The facility 's census was between 145 and 152 (different numbers were provided by the staff), which would have required 623 staff hours. Also, only 5 staff have routinely been assigned on the overnight shift (between 11:00 pm and 7:00 am), which is when many of the have occurred.
Observation on / at 6:00 am showed there were 5 staff on duty (3 on the west wing, 2 on the south wing where there are residents who need more assistance, and where the was alleged to be occurring). The total census was 145 residents.
A review of the "rounding tool" used by staff to record resident whereabouts each hour revealed, on / at 8:00 AM noobody knew where Resident #20 was. On / at 2:00 PM, the rounding tool was not completed in the 200's, 300's, and 400's . On / / at 3:30 PM nobody knew where Residents #68, #69, #70 and #30 were located.

B) In an interview on / at 6:39 AM, Resident #71 stated, "I'm , but I know what is right or what is wrong, but something is wrong in here. We have a male resident that one lady that can not talk or do anything, she is totally lost. He kisses her, he touches her. I called her sister and I told her that she needed to care about her because Resident #72 likes to her sister." Resident #71 stood in front of the photograph posted on the wall and stated, "this is the resident and her sister. Staff know that Resident #72 liked to touch women and they do not do anything. He does not have specific time he do it. "
In an interview on / at 8:40 A.M. Resident #37 stated, she heard resident #72 touches Resident #73 and kisses her. I saw her that she went to the bed with a man that took her by her hands

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FLORIDIAN GARDENS ASSISTED LIVING FACILITY	**17250 SW 137 AVENUE MIAMI, FL 33177**

SUMMARY STATEMENT OF DEFICIENCIES
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to his room, (She did not provide the resident's name). She stated, "caregivers know that." She stated, last Sunday we had only two staff working here, Caregivers A3 and Z and they got crazy because they needed to assist a lot of people. We are under staffed here.

In an interview on / at 9:06 AM Resident #74 stated, "we have Resident #72 that abuses Resident #73, he kissed her and touched her. Resident #73 is a type of person that will go with anyone that leads her by the hands. I'm not a doctor, but she is not mentally competent to know what's right or wrong. I pointed a few times to Resident #72 to stop kissing and touching her. I never get physical with him, but I did verbally. Staff knows that he likes to touch women, but the staff just separate them when they are together. I do not like to talk to the Administrator because she likes to drop the ball every time that I have a major concern...."

In an interview on at 9:50 AM Resident #73's sister stated via phone, " I'm the sister not a daughter. I love my sister so much and go there every day in the afternoon to see her. I've been told that Resident #72 likes to kiss and touch my sister. This is something that's been going on for a while, over a year. I went to the old Administration and complained. I told the Administrator that something's going on and needs to stop. I went personally to Resident #72 and his mother's talk to him, I told him that I do not want him to touch or kiss my sister anymore. I confronted staff, I do not remember her name, she was on the defensive telling me that was impossible that a resident had been touching my sister. I talked to the new Administrator about a month ago and informed the same resident was continuing molesting my sister and other ladies." Resident #73's sister further stated, " Yes I know Resident #72 is that way; he does it also to Resident #3, he puts his hands under the blanket. Resident #72 did to this to other ladies that were seated in wheelchairs with blankets on their legs; he put his hands under and between their legs. I heard from residents that these continue."

Review of Resident #73's file revealed, the resident admission date was on . The Health Assessment (AHCA 1823) dated showed diagnoses to include: , , , , ( ); Alert and Orient X 2 and forgetful at times. The resident was independent for ambulation, eating, toileting, and transferring but needed supervision with bathing, dressing, self-care. The Health assessment dated showed Diagnoses: , , confuse. Resident was independent with eating but needed supervision with ambulation, bathing, dressing, self-care, toileting, and transferring. The Residency Agreement dated / / showed the facility will assist with third party services, reporting , neglect and and every employee from the facility was required to report , neglect and to law enforcement and to the Florida Hotline.

Review of Resident #73's progress note from / until / showed that there was no documentation about the by another resident. There was also no documentation about the family concern or complaint in the resident's file.

A review of the facility's internal incident report completed on / showed on / / at 4:00 PM Resident #73's sister reported, Resident #72 sat close to her sister and she was scared that he can

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have a attitude with her sister. The facility informed Resident #73's sister that Resident #73 was the one that wanted to sit near to Resident #72. Caregiver Z1 who received the report immediately reported to the supervisor. Facility follow up to Resident #72 was done on / by Caregiver B and it showed the Resident did not have any abnormal behavior. The Resident was told not to stay close to Resident #72 as a preventive measure.

In an interview on / at 11:17 AM, the Administrator revealed that Resident #73's sister informed her that residents told her that her sister has been touch by another male resident. The Facility's administrator stated, she informed staff responsible of the cameras to check them. She stated, "I do not remember when it happened but I made the report and we do have the incident report here. " She stated, staff responsible for the cameras checked the camera and nothing showed in there; the only thing that showed was both of them seated together. She stated, "I haven't seen the camera myself. They reviewed it for a certain time because the cameras were out of order for some period of time. She stated, Resident #73's sister reported the incident to the other administration. The administrator reported, "I went to ask the CNA's one by one in person and no one knew anything about the incident. I addressed the staff to observe Resident #73 that men can not sit next to her. I did not tell staff clearly the reason for privacy. "

In an interview on / at 12:54 PM, Caregiver A3 stated, "I'm working here for about 2 and 1/2 years and no incident has been reported to me. We do not sit Resident #73 near men, she have to be away from men because she pinch and touch them. The Administrator was informed about the incident that Resident #72 touched Resident #73 improperly and this is the reason that we are looking after her."

In an interview on / at 1:00 PM, Caregiver D1 stated, "I'm a CNA for the area of . I have been working here for 1 year and 4 months and my shift is 6:30 AM to 3:00 PM. I have not seen any incident with Resident #73, but her sister informed the resident has been touched and kissed by Resident #72. The facility administrator never notified the resident needed to be supervised."

Review of Resident #72's file revealed, the admission date was / . The Health assessment (AHCA from 1823) completed on / showed diagnoses , DMII, . The resident's or behavioral status was alert and oriented. Resident was independent with ambulation, eating, toileting and transferring and needed supervision with bathing, dressing and self-care.

In an interview on / / at 4:17 PM, the Administrator stated, one action in place was to keep Resident #73 supervised all the time and the other action was to move Residents #72 and #73 to different wings, but both of the family members refused to move them to another area.

In an interview on / at 1:00 PM Caregiver B revealed, the Administrator informed her that Resident#72 had an incident with Resident #73, but the Administrator did not tell the reason why both residents needed to be in total supervision or staff needed to report any inappropriate attitude between them. Caregiver B did the follow up of the incident and when she did it, she didn't have detailed

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information about the incident. She stated, "the incident was that Resident #72 was inappropriately touching Resident #73's legs but I did not see the incident with my eyes, I was informed by the administration."
In an interview on I/ at 1:03 PM, Resident #74 stated via the phone, "I do not count the time, I do not have track of that because I have to take care of my own things. The last time that happened was like a month ago, and he is a repeat offender."

C) On I/ at 5:50 AM observed in that Resident #59 was in wheelchair, observed the resident had a sign in her read, "Keep door Open." There was a odor in the hallway by the resident's .
Observation on I/ at 6:12 AM revealed, there was a strong smell in the hallway between 203, 204, 205 and 206.
Observation on I/ at 6:18 AM revealed, there was a odor in the south station area.
Observation on I/ at 9:19 AM revealed, Caregiver L was with 9 residents, most residents were in wheelchairs, or had wheelchairs next to them.
Interview on I/ at 9:19 AM with Caregiver M revealed these residents need a little more supervision.
Observation on I/ at 9:18 AM revealed, Residents #51 and #55 sat in wheelchairs in # . Resident #51 stated, "I received hospice care and they came here in the morning and change my adult brief and in the afternoon by facility staff. She stated, we do not have staff here, if I need a HHA (Home Health Aide) I have to transfer with my wheelchair to look for them. On the weekends we have only two staff here for a lot of people. "
D) A review of Resident #50's file revealed, the resident was , . The Health assessment (AHCA form 1823) completed on / / showed the medical history and diagnoses included: normal , , generalized , . Physical or sensory limitations: difficulty walking. Special precautions: precautions. No was identified under hospice services in the health assessment. Activities of daily living included, needed assistance for all ambulation, bathing, dressing, eating, self-care, toileting, and transferring. But, the resident was receiving hospice care.
Review of Resident #50's hospice nursing assessment completed on / / revealed, reposition every 2 hours and as needed.
A review of the facility's internal incident report completed on I/ at 10:00 AM revealed, Resident #50 had not been out of bed for three days. The caregiver wrote, the Resident did not get out of bed since Tuesday and was found during change time with red spots on the right thigh.
Interview on I/ / at 8:38 AM with the Administrator revealed, Resident #50 was not in continuous care with hospice. The facility staff was responsible for taking care of hospice residents and repositioning after hospice staff left the facility.
In an interview on I/ at 8:40 A.M. Resident #37 stated,"last Sunday we had only two staff

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working here, Caregivers A3 and Z and they get crazy because they need to assist a lot of people. We are understaffed here. "
In an interview on / at 10:23 AM Resident #73's sister stated, "They are very understaffed, especially during meals." I noticed that the facility does not have enough staff to assist all the residents. During weekends, I observe only two staff in this area. I introduced myself to the new administration and he showed me the new plan for the facility. I'm concerned about my sister."
In an interview on / at 1:00 PM Caregiver D1 that stated, on Saturday and Sunday there were only two CNAs (Certified Nursing Assistants) on the floor for the south wings, one CNA for in the 500's and one CNA for in the 700's.

Class I

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on observation, record review and interview, the facility did not ensure that 1 out of 30 sampled employees (Staff B-1) had received in-serve training in resident elopement response policies and procedures, Emergency Preparedness and Evacuation, Providing assistance with the activities of daily living (ADL ' s), Reporting major incidents, Reporting adverse incidents, Resident rights, Recognizing and reporting resident , neglect, and within 30 days of hiring.
Findings included:
Observation on / at 6:18 a.m., Staff B-1, Licensed Practical Nurse (LPN) supervisor was in the facility south wing area assisting residents with self-administration of medications.
Record review revealed that Staff B-1 (LPN) did not have documentation of in-service training in resident elopement response policies and procedures, Emergency Preparedness and Evacuation, Providing assistance with the activities of daily living (ADL ' s), Reporting major incidents, Reporting adverse incidents, Resident rights, Recognizing and reporting resident , neglect, and within 30 days of hire .
During an interview on / at 2:22 P.M. Staff , resource (HR) did review Staff B-1(LPN)'s personnel record. Staff B-1 acknowledged that the record was missing in-services training.
Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation, record review and interview, the Assisted Living Facility failed to prepared and served therapeutic as ordered by the health care provider for 1 one out 74 (# 25) samples residents. The facility failed to the facility failed to document a resident ' s refusal to comply with a therapeutic diet and provide notification to the president ' s health care provider of such refusal. The facility failed to

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encourage residents to participate in menu planning.
Finding included:
During an interview on / / at 9:06 a.m., Resident #74 stated that he had a concern about the food. He stated "we have a menu but we have every day the same things, over and over. We do not participating in the elaboration of the menu; I've been in another assisted living facility that we had a monthly council meeting were residents can expressed their concern. I can cooperate with that if they want. I've been here for 2 years and we never had one meeting."
Lunch observation on / at 1:48 p.m. showed that Resident #25 was sitting at the table with a plate of rice, fried plantain and a cup with bean soup.
Record review of Resident #25's Health Assessment (AHCA form 1823) completed on showed medical history and diagnoses: toxicity, , DMII, diastolic chronic failure, status post left , , , . The resident had unsteady gait physical or sensory limitations and precautions. The Resident #22 needed assistance for ambulation, bathing, dressing, self-care, toileting, and transferring but supervision for eating. Special diet instructions revealed calorie controlled no added salt, mechanical soft, and no concentrated sweet. The resident did not have documentation that he refused the therapeutic diet.
During an interview on / at 9:36 a.m., Resident #26 stated " the only complaint that I have here is the food. I want different kind of food."
During an interview on / at 2:00p.m., the Administrator acknowledged during a review of Resident #25's file that the resident health assessment did have special diet instructions for a mechanical soft diet.
Uncorrected
Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the Assisted Living Facility failed to ensure that all existing architectural, mechanical, electrical and structural systems were maintained in good working order.

Findings included:

Observation on / at 6:26 AM revealed that in Resident #45's ceiling texture was removed on one part, and leaving evidence of repair exposed.

On at 9:30 PM, observed in hallway walls that were in need of repair and to be painted over. The wall borders had holes and wet brown stains.

Interviewed on / at 4:50 PM the Administrator stated "Just missing paint because there was a

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leak in one of the bathrooms and it came out to the hallway and the same in Resident #45's room ceiling, it had a leak."

Interviewed on at 9:36 PM, Staff #A2 stated that the facility is in the process of doing several repairs to the building. (photo)

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on observation and record review, the Assisted Living Facility failed to ensure that hospice residents had an accurate interdisciplinary plan of care for one (#1) out of 74 sampled residents.

Findings included:

Review of Resident #1's record revealed that Resident #1 had a doctor's order for hospice services since .

Review of Resident #1's hospice record in the facility showed that Interdisciplinary Meeting comments for I/ revealed that resident had a 16 Fr/10 cc. incontinence managed by .

Observation on I/ at 12:10 PM in the dining I that Resident #1 did not have any visible .

In an interview on I/ at 12:11 PM the Registered Nurse B confirmed the Resident #1 did not longer have the , and that the hospice nurse had removed it.

Uncorrected
Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview the facility failed to complete an adverse incident report for 9 out of 9 residents (Residents #6, #7, #21, #61, #62, #54, #67, #25, and #20), 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 included:

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Review of Resident #7's Hospital Discharge record revealed that Resident #7 was admitted into hospital on 09/17/2016 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 / .

Review of Resident #21's record revealed that Resident #21's admission date to facility was on and discharge date was on . Resident #21 transfer out form dated / showed a Broncho . Resident #21 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- , .

Review of Resident #61's hospital discharge record revealed that Resident #61 was seen at the hospital on for " (on) (from) unspecified stairs and steps- with mild closed head and left hip ."

Review of Resident #62's hospital discharge revealed that Resident #62 was seen at the hospital on for " (stretching or tearing of ligaments, the fibrous tissue that connects bones and joints) of the right , joint (wrist joint), on the same level by slipping, single laceration (deep cut or tear in skin or flesh) to the forehead, and single (injured tissue or skin in which capillaries have been ,) with soft tissue hematoma to the forehead." Photo in record showed for staples in the forehead.

Review of internal ALF incident reports revealed that Resident #54 on (Thursday) at 3:50 AM- found sitting in the skin broken on the arms and on the left leg, and "hit in the face" according to the chart. Resident went to the hospital.

Review of internal ALF incident reports revealed that Resident #67 on / / (Wednesday) at 2 PM while walking alone, slipped and . She complained of shoulder pain. Resident #67 went to the hospital and was recommended the used of sling.

Review of Resident #25's hospital discharge record revealed that Resident #25 was seen on / / at the Hospital for on the same level by stumbling, single superficial laceration to the scalp, multiple superficial skin of the left upper arm and of the left , multiple with soft tissue

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hematoma to the forehead and left periorbital area, and gait abnormality-unsteadiness. CT WO CON (diagnostic imaging procedure that uses a combination of X-rays and computer to produce horizontal, or axial, images (often called slices) of the including the bones, muscles, fat, and)conducted on / / revealed left frontal scalp hematoma without evidence of acute abnormality.

Review of internal ALF incident reports revealed that Resident #20 on / / (Friday) at 1:40 AM found in the floor with redness on the right eye and right side of the head. Resident #20 transferred to hospital.

In an interview on / at 9:20 AM the Administrator revealed that facility has not submitted the incident reports to AHCA.

Class III
Uncorrected

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on observation, record review and interview, the facility failed to maintain an updated employee roster within the Agency for Health Care Administration (AHCA) Background Screening Clearinghouse. This affected 4 out of 30 personnel records reviewed.
Findings included:
Observation on /_____ at 6:18 a.m., Staff B-1 was inthe facility's south wing area assisting residents with self-administration of medications.
Review of the personnel record showed that Staff B-1 was working at the facility and she did not have an eligible Level II background screening. Further review revealed, Staff V and Staff L, home health aides (HHA) were currently working at the facility.
Review of the Agency for Health Care Administration (AHCA) Background Screening Clearinghouse database showed the followings: Staff G was not working at the facility and the background screening clearinghouse did not have a termination date. Staff B-1 did not have an eligible background screening. Staff V and staff L were not registered for the background screening clearinghouse.
During an interview on / at 2:22 PM, Staff R stated, staff G's termination date was two months ago. She further stated, "I've been trying to keep up." Staff R acknowledged, the clearinghouse roster was not up to date.

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Z815 - Background Screening; Prohibited Offenses - 408.809, 435.02(2), 435.06

Based on observation, record review and interview, the facility failed to maintain documentation of the results of a background screening onsite in the facility's personnel files for 1 of 30 employee's sampled (Staff B-1).
Findings included:
Observation on / / at 6:18 a.m revealed Staff B-1, Licensed Practical Nurse (LPN) supervisor was at the facility south wing area assisting residents with self-administration of medications.
During a review of the personnel records, there was no documentation of an eligible Level II background screening for Staff B-1(LPN). The documentation found in the record showed the background screening status as, "agency review required."
A review of the Agency for Health Care Administration (AHCA) background screening database revealed, an eligible background screening for Staff B-1(LPN) status as "agency review required."
During an interview on / / at 2:22p.m., Staff R (Human Resource) reviewed staff B-1 (LPN)'s personnel record. She acknowledged, the background screening did not have the eligible result and the status showed, "agency review required." She stated, "I'm going to the website now to do it."

Unclassified

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11968608 Y1	A. Building B. Wing Y2	Y3

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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0052 Reg. # 58A-5.0185 (3) LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE 12/24/16	TITLE HFES	DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/4/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: RB8P12