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	AL11953432	R 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN GARDENS ALF	**12221 WEST DIXIE HIGHWAY** **MIAMI, FL 33161**

SUMMARY STATEMENT OF DEFICIENCIES
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Z813 - Results of Screening & Notification in File - 59A-35.090(3)(c), FAC

Based on observation, record review, and interview the facility failed to have documentation of an Attestation of Compliance with Background Screening in 1 of 34 sampled staff files (HH).

Findings included:

On . . . . Staffing schedule review showed the facility's updated staff schedule reflected Staff HH worked in facility.

Record review revealed Staff HH had the eligible Level II background screening result in the personnel file. Further review showed that Staff HH was hired on . . . . . and the Level II Background Screening was dated with Eligible status.

Staff HH stated that she had returned to work at the facility after living in another state for five months. The Attestation of Compliance with Background Screening was not signed.

During an interview on . . . . . at 2:35 pm Staff A acknowledged that Staff HH worked in the facility, but they did not have the signed attestation in the file.

Unclassified

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

Based on observation, record review, and interview the facility failed to have the Level 2 background screening for the maintenance person who has access to residents common areas and . . . .

Findings included:

On . . . . at 9:30 am the maintenance person (Staff II) was observed coming into Unit 6 to evaluate a dilapidated sink. The maintenance person remained in the resident's unit without facility staff preset, to continue to evaluate and make the repair.

Record review showed the facility had no proof of the background screening Level 2 for Staff II.

On . . . . . at 11:10 am the Administrator stated Staff II does the facility's maintenance and repairs, and acknowledged that Staff II has to work unescorted in resident . The Administrator further stated that the facility had no background screening for Staff II because he was a contractor and not a

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facility Staff. The Administrator stated that she had no documentation of the Contract between the facility and Staff II.

Unclassified

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c) FS

Based on record review and interview the facility failed to provide a new Level II background screening for an employee who had a break in service for more than 90 days for 1 of 34 sampled employees (Staff HH).

Findings included:

A review of Staff HH's personnel record revealed that the application with references/hire date and the Level II Background Screening was dated , and , with Eligible status.

On at 1:36 pm Staff HH stated, "I worked in facility but moved for 5 months to Texas."

On at 1:40 pm the Administrator stated, "Staff HH came back to work at the facility when she returned from Texas."

Unclassified

0000 - Initial Comments

A complaint (CCR #2016010073) survey revisit was conducted at Eden Gardens ALF (License # 8209) on and concluded on . The following deficiencies were identified at the time of the survey:

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

Based on record review and interview the facility failed to ensure that 2 of 80 sampled residents met the criteria for continuous residency (Residents #32 and #80).

Findings included:

Observed during the facility tour on at 10:35 AM, the hallway approaching had a strong odor. Entered the found Resident #80 lying on the bed, with an empty urinal on

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top of the dresser. # had a very strong odor.

Interview with Resident #80 on at 10:35 AM revealed the resident went to the . Resident #80 stated he did not use incontinence briefs.

Staff D stated on at 10:40 AM that Resident #80 refused to wear incontinence briefs. She stated that the Resident #80 sometimes on the floor and/or in bed.

Record review found Resident #80's health assessment stated he was independent with activities of daily living (ADLs) including toileting. Resident #80's observation log stated on , " resident continues the same behavior as last month ...encourage him to keep a clean hygiene. " On , " he refuses for staff to assist him with showers, or any other assistance.

Interview with the Administrator, Manager, and Director on at 2:20 PM. The Administrator acknowledged that Resident #80 ' s a order and that the resident refused to wear incontinence briefs.

Review of the individual and facility records for Resident #32 revealed that he was admitted to the facility on and had a long history of . The resident had been counseled several times by the facility staff regarding this, including after he experienced -related injuries, blackout episodes and hospital visits, and was returned to the facility by the police. The resident continued to go out and drink almost on a daily basis, and there was no documentation of an updated, accurate assessment of the resident's needs.

On at 12:10 pm the Administrator stated that the resident will be moving out of the facility at the end of the month.

Uncorrected
Class III

0031 - Resident Care - Third Party Services - 58A-5.0182(7) FAC

Based on record review and interview the facility failed to coordinate with the third party providers to facilitate the receipt of care and services provided to meet the , resident's needs. This was evidenced by the failure of the nurses to accurately document the prescribed medications that were administered for 4 of 85 sampled residents (Residents #5, #72, #82, #83, and #84).

Findings included:

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Record review revealed that there was no documentation that Residents #5, #72, #82 and #83 had received injections on in the morning and that Resident # 84 had an order for Glargine inject 10 units under the skin daily. There was no documentation of the resident receiving the injection.

During the exit conference with the Administrator, acting Manager, and Operations personnel on from 2:00 pm to 3:00 pm. The facility staff did not provide any evidence that the nurses from the home health agencies documented that services were provided to the residents on .

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on observation and record review the facility failed to follow its own elopement policies for 8 of 19 sampled residents identified as at risk of elopement (Residents #9, 11, 12, 13, 16, 19, 24, and 25).
Findings included:
A review of the facility's policy and procedure regarding elopement showed Procedure #3 stated:
"If elopement risk is determined, the following actions will be taken:
a) an identification bracelet will be placed on resident's wrist with his/her name and facility contact information;
b) a picture of the resident will be placed in the "Elopement Risk Binder" where all pertinent resident information will be easily available if reporting is needed; and
c) all staff members will be informed of "at risk" residents and the "Elopement Risk Binder" and its contents."
A review the health assessments and resident records showed Residents #9, 11, 12, 13, 16, 19, 24, and 25 scored within the identified risk range on the elopement assessment ,or were considered at risk of elopement due to factors identified by staff. Further Record review showed that Residents #9, 11, 12, 13, 16, 19, 24, and 25 were in the facility's elopement risk log as of .
Observations on at 12:46 PM found Residents #9, 11, 12, 13,16, 19, 24, and 25 did not have functional elopement risk bracelets on their arms. Residents # 11,13,16 had bracelets with a paper area for the written identifying data which had faded out, so no writing was visible. Residents # 9, 12, 15, 19, 24 had no bracelets.
The Administrator stated on at 2:30 p.m. during the exit interview that the bracelets' writing wears off after a few showers, and that some residents remove the bracelets.
Uncorrected
Class III

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0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observation, interview, and record review the facility failed to maintain an accurate daily medication observation records (MORs) for 1 of 85 sampled residents (Resident #81).
Findings included:
During tour of the facility on at 7 am, Resident # 81 was observed with a dressing on her left thumb.
Resident #81 stated on at 1:45 pm that she keeps an over the counter medication in her (Double Bacitracim and Polymicin) and that she was given the prescription for the at the day program that she attends. She also stated that she partially lifted off her thumb fingernail and that she goes every morning to the staff office at the facility and that the medication technician cleans her finger with , applies the and fixes the protective dressing for her.
Record review showed that the cream was not listed on the MORs. Further record review showed that the protective dressing was being applied to the resident's hand by someone that was not a licensed nurse.

Uncorrected
Class III

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

Based on record review and interview the facility failed to ensure that the medications are locked at all times out of the sight of the residents.

Findings included:

On at 8:00 am observed a box of Suprep Bowel Prep Kit prescribed for a resident being stored on top of the counter at the nursing office unlocked and there was a resident inside the nursing office. Observed staff meeting individually with residents in a small sub office, and a resident standing unescorted in the larger office waiting to enter the sub-office to see staff.

During the exit conference on at 3:00 pm the Administrator stated that the resident was not alone inside the office when the medication was unlocked.

Uncorrected
Class III

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

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Based on observation and interviews, the facility failed to provide a living environment free of hazards, where all systems and appurtenances were maintained in good working order.

Findings included:

Facility tour on between 5:30 am and 3:30 pm, observed the following:

Five empty bedframes stored in the hallway of the main building.
debris and discarded durable medical equipment in a back yard.
No working lights in the to , and no working lights in the hallway outside of that .
A foul odor in # , #26 (smoke), and #29 ( ); feces on the bed sheets in
A that opened only with difficulty in #
Residents smoking in # . Brown stains on the shower.
the falling away from the wall in , with the pressboard cabinet surrounding the sink appearing waterlogged as it apart. At 9:15 am, the Administrator called the facility's repairman into the unit to see the sink. The repairman was left in the unit alone to fix the sink. The Administrator informed the unit's resident (Resident #86) that the repairman was staying behind. "The administrator stated "She doesn't usually let them into her unit, and she doesn't like him being in there, so it's hard to fix anything."
A hole in the and a mildewed shower curtain in #
No top on the toilet tank and missing tiles in the shower in #
Rust in the bathtub in # .
Tile missing from the shower, peeling paint on the walls and broken blinds in #
A foul odor in .
A foul odor and a missing drawer in the nightstand of # .
Peeling paint in the # .
Tile Missing from the # . At 9:48 am, Resident #85 stated "A small mouse is coming through the hole in the ."
Rust in the bathtub in # .
A hole in the and missing shower tiles in the shared #
No shower curtain in the shared # .

Findings were reviewed with the Administrator and other Staff D during the tour on .

Uncorrected
Class III

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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 file an incident report within 1 business day and 15 days after the occurrence of an adverse incident for 3 out of 85 sampled residents (Resident #3, 52, and 85).

Findings included:

1) A review of Resident #3's record revealed that the resident moved to another facility on and that on the resident was out of control, aggressive and and hitting other residents and the police were called. The police transferred the resident to the hospital for further evaluation. No adverse incident report was filed.

On at 12:00 pm the Administrator stated that the resident had been taken to the hospital by the police, under .

2) A review of Resident #52's record revealed on resident between his wheelchair and bed while transferring to bed. Found by staff at 1:00 pm. On Resident #52 trying to transfer, found at 2:30 pm. On at 12:30 pm Resident #52 was going to the , felt weak & down per facility records. On at 1:30 pm Resident #52 was found on the floor, lost his balance. No preventive action noted in resident file by the facility.

Documentation provided by the facility on showed Resident #52 also on . "Resident found on floor, in hallway near his . Resident stated that he lost his balance, was feeling weak. Staff called rescue. He was transferred to ...hospital. On resident found on floor. Resident stated he lost his balance while going to the . Stated he hand pain in (left) L hand. Resident transferred to ...hospital. On returned (diagnosis) : ( ) FX L Wrist, soft . Staff moved resident to a to dining medication to monitor resident."

Record review found Resident #52 on , , , and . The facility failed to complete adverse incident reports regarding Resident #52 multiple where the resident required a higher level of care due to inquiries.

3) A review of Resident #85's record revealed on at 2:10 am the resident found on floor during rounds, right hip injury. On Resident #85 was found on floor; while transferring.

Documentation provided by the facility on showed Resident #85 on . "Resident found on the floor at 7:49 pm by staff. Sitting on the floor and resident stated that she was going to her

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closet and . Stated that she was used to walking and forgot for a moment that she is not ambulating as before. Refused to go to the hospital. Physician and guardian advised. On resident found on floor at 2:15 am by staff. Resident states that she out of bed, resident states that she wanted to sit in wheelchair. Resident sent out via rescue to ...hospital. On returned from ...rehabilitation. Resident returned with (status post) s/p of (right) R hip."

The facility failed to complete adverse incident reports regarding Resident #85 where the resident required a higher level of care due to inquiries.

On the facility documented that "adverse incidents reports was not warranted pursuant to statue and rule," regarding Residents #52 and 85.

Uncorrected
Class III

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(8) FAC

Based on record review and interview the facility failed to ensure that 1 out of 34 sampled staff received a minimum of 6 hours of specialized training in working with individuals with mental health diagnoses within 6 months of employment (Staff G) .

Findings included:

Record review revealed that Staff G was hired on . Further review showed that Staff G completed 3 hours of training in limited mental health on . There was no documentation of 6 hours of Limited Mental Health training.

On at 2: 20 pm the Administrator acknowledged the facility had no documentation of the 6 hours of Limited Mental Health training for Staff G.

Uncorrected
Class III

N276 - LNS - Nursing Services - 58A-5.031(1) FAC

Based on observation, record review, and interview the facility failed to obtain a license prior to providing limited nursing services. The also readmitted 1 of 85 sampled residents who had a (Resident #32). The facility provided care and dressing changes to 1 of 85 sampled residents (Resident #81).

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Findings included:
1) A review of Resident #32's facility and hospital records showed that the resident had broken two fingers on and had surgery to repair right long and ring finger middle , and right small finger , base . The resident was wearing a on the affected area.
Review of the facility license revealed that the facility does not have limited nursing services component.
2) During tour of the facility on at 7 am Resident # 81 was observed with a protective dressing on her left thumb.
Resident # 81 stated on at 1:45 pm that she partially lifted off her thumb fingernail and that she goes every morning to the staff office, and that the medication technician cleans her finger with , apply the and do the dressing for her.

Class III