STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968608	**01/30/2017**
NAME OF PROVIDER OR SUPPLIER **FLORIDIAN GARDENS ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **17250 SW 137 AVENUE MIAMI, FL 33177**	

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

0000 - Initial Comments

Resident wellness monitoring surveys were conducted on through . Floridian Gardens Assisted Living Facility with Limited Mental Health component, license # 12484 had the following deficiencies identified at the time of the survey:

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

Based on record review, observation, and interview the facility failed to provide care and supervision appropriate to the needs of seven of 15 residents (#1,2,3,4,5,6, 11) in order to prevent resident resulting in injuries including broken ribs, pain, and head injuries.

Findings include:

Review of Resident #1's health assessment (AHCA form 1823) showed resident is with diagnoses of and high , , is ambulatory with assistance ambulates with walker and is alert and oriented x 2. The resident needed precautions. The resident needed assistance with ambulation, bathing, and dressing, is independent with eating, and required supervision with self-care , toileting, and transferring.

Review of Resident #2's health assessment (AHCA form 1823) showed that the resident was with diagnoses of , was alert and oriented x 3, had universal precautions. The resident was independent with ambulation, bathing, dressing, eating, toileting, transferring, and requires supervision with self-care .

Review of Resident #3's hospital record revealed that the resident suffered several while residing in the facility. On Resident was transferred to the hospital for shoulder pain, Hospital record stated, "the problem was sustained at a facility where she lives, resulted from a , from a standing position." On the Resident from an upright position. Patient around 1 PM due to slipping and on her left shoulder. The Resident was diagnosed with 's , and had at the facility on . The hospital record stated, "the patient from a height, unknown because the patient was found sitting on the floor on her bed side as per ambulance record." On the Resident was admitted to hospital for a complaint of leg and arm .

On at 10:53 AM observed Resident #3, who was identified as at risk for . The resident did not wear the yellow wrist that the facility had instituted as a precaution, to be worn by residents at risk of .

Review of Resident #4's hospital record revealed that on , the Resident went to the hospital for a left frontal scalp hematoma. Record review also found on the resident was found on

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the floor at the facility, having sustained a blow to the head and had a small laceration to her forehead. Resident #4 was complaining of right wrist pain.

Review of Resident #5's hospital record revealed on , the Resident to the floor, but he did not lose . He did sustain some to the right side of his face. On , the resident was hospitalized due to complaints of upper extremity pain. The resident had been complaining of left shoulder, neck and ankle pain since his two weeks earlier. On Resident #5 was hospitalized due to a diagnosis of multiple right .

A review of facility's internal incident documentation revealed on at 4:40 AM Resident #1 and Resident #2 were both found on the floor due to a . Resident #2 while she was helping Resident #1 go to the . Resident #1 suffered a on her right palm and on her right knee, and Resident #1 had a small behind his head.
Review of facility's internal incident report revealed Resident #11 was found on the floor by her after the heard Resident #11 hit the floor. The went for help.
An interview on 12:22 PM with Staff E revealed that Staff E "passed by the hallway and heard the asking for help and when I walked I in found Resident #11 on the floor. According to the , Resident #11 just had . Another staff called 911 while I assisted her. She had the right ankle. She remained in her that time, on the floor. We did not move her. She used to have a half-bed rail, supervision every hour, and a yellow ."
In an interview on at 12:40 PM Resident #6 in the dining that she was resting in bed when she saw her get out of bed and walk to the door when she . She immediately got out of bed and started to scream, "Resident 11 se cayo" (Resident 11) and staff immediately came to help.

In an interview on at 12:29 PM, Staff A stated, "we try to be more vigilant and stay more in touch with the residents, explain to them and make them more familiar and also their family, talking to the residents and families, and doing more frequent rounds."

Class II

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

Based on interview and record review the facility failed to honor resident's rights for one of 14 sampled residents (Resident #10). The resident's property was lost or stolen by facility staff.
Findings include:
A review of an internal facility report showed that Resident #10 complained that his belongings were stolen by Staff F.

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In an interview on at 7:30 AM Staff stated, "Resident #10 gave to Staff A a new pair of jeans and a shirt to be washed and they were never returned to the resident. Police was called and they said they couldn't do anything. A state agency was called. Staff F was on probation until the state agency's investigation was completed. The state agency told us that Staff F's history did not match reports, and we decided to terminate."

Record review revealed that there was no documentation of the facility retraining the remaining staff about resident rights, or about procedures for handling resident laundry or personal belongings.

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on record review and interview the facility failed to follow the correct procedure when assisting one of 15 sampled residents (#14) with self-administration of medications. The Staff gave another resident's medication to resident #14, which resulted in Resident #14's hospitalization on the due to issues.

Findings include:

A review of Resident #14's hospital record revealed Resident #14 is a male with history of Parkinson's who presented from assisted living facility to hospital for , the patient was accidentally given medication intended for his on . The resident was hospitalized with a diagnosis of drug over dose- . Resident #14 was transferred by emergency department complaining of and possible ( ) . Disposition observed in hospital record stated: hospitalization ordered by hospital physician for observation. Preliminary diagnosis is adult - Drug over dose- , status observation, condition is serious, problem is chronic, and symptoms have worsened. Further review of hospital record stated: The symptom(s)/episode began/occurred today at 12:00 occurred at assisted living facility, patient mistakenly given 81 mg , 100 mg , 750 mg , 25 mg , , 600 mg , , 40 mg , , 10 mg . Patient stated he felt weak and lightheaded afterwards. Resident #14 ' s labs were observed to have above high normal levels of and / ration, and B-type natriuretic peptide. Associated signs and symptoms: pertinent positives: .

A review of the American Association's description of shows" a rate of less than 60 beats per minute. Complications of can include: failure, , (loss of), pectoris (chest pain), low or high , ."

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A review of Resident #14's health assessment dated revealed Resident #14 was , with diagnosis of , ( ), Parkinson , and High , . Resident was awake, alert, oriented to time and place. Resident needed assistance with ambulation, bathing, and dressing, was independent with eating, and required supervision with self-care ( ), toileting, transferring. Resident needed assistance with self-administration of medications.

A review of the facility's medication observation record (MOR) for the resident revealed that Resident #14 had prescribed Binatoprost eye drops at 7:00 PM, , 10 MG 7:00 PM, signed (H) for resident is out to hospital, and , 10 MG 7:00 AM 1 MG 7:00 AM, , 20 MG 7:00 AM, , 2 Puffs 7:00 AM and , , 7:00 AM signed by staff indicating that these medications were given to the resident.

On at 4:01 PM Staff B stated, "I knew about that incident when the Staff I gave Resident #14 the medication that belonged to Resident #15. Staff I said she got with the resident's name, because when she stated to Resident #14 all the medications that belong to Resident #15, then Resident #14 replied yes. Staff I, admitted she gave the wrong medication to Resident #14 and we sent the resident to the hospital. The preventive action was to re-train all of the staff with the medication procedures. The reason we did not report the incident because, the Agency (AHCA- the Agency for Health Care Administration) was here to investigate several days after the incident."

Record review showed that there was no documentation of the incident in Resident #14's file or in Resident #15's file. Further record review showed that there was no documentation of the incident reported to the Agency, and no investigation by the Agency occurred.

Record review showed that no documentation of an internal investigation of the error, or any staff retraining, was provided by the facility.

Class II

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

Based on record review and observation the facility failed to file a one day incident report and a 15 days incident report for incidents involving two of 15 sampled residents (Residents #3 and #8)
Findings include:
Review of Resident #3's hospital record revealed resident has suffered several while residing in the facility. The Resident suffers from 's , resident suffered a on 11/ . Hospital record stated, "The patient from a height, unknown because the patient was found sitting on the floor

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on her bed side as per ambulance record. On the Resident was admitted to hospital for complaint of leg and arm . On The Resident from an upright position. Patient around 1 PM due to slipping and on her left shoulder. On Resident was transferred to the hospital for shoulder pain, Hospital record stated " The problem was sustained at a facility where she lives, resulted from a , from a standing position. "

On at 10:53 AM observed Resident #3, who was identified risk for . The resident was not wearing the yellow wrist that the facility had instituted as a precaution, to be worn by residents at risk of .
Review of facility's internal incident report revealed On , 2016, Resident #8 was taken to the hospital due to aggressive behavior.
Review of the Agency for Health Care Administration's (AHCA) Incident Report Database revealed there was no averse incident report completed for Resident #3 and #8.
Class III

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

Based on record review and interview the facility failed to ensure that one of nine sampled staff were registered on its employee roster in the Background Screening's Clearinghouse Database (Staff A).

Findings included:

A review of the employee roster in the Background Screening's Clearinghouse Database showed Staff A, who had been hired on as the Assistant Administrator of the facility had not been added to the database.

On at 9:30 AM the Assistant Administrator stated that he was not on this specific background screening database because he was hired by the main office that runs different facilities.

Unclassified

Z829 - Moratorium; Emergency Suspension - 408.814 FS

Based on record review and interview the facility failed to comply with a legal order from the Agency for Health Care Administration (AHCA) which imposed an immediate moratorium on admissions. The facility re-admitted two of fifteen sampled residents without consulting with the AHCA field office after the residents were transferred out to a hospital.
Findings included:
Record review showed that a moratorium on admissions was imposed on the facility on at approximately 1:05 PM.
Interviewed on at 10:00 AM, Staff A stated that the facility readmitted Resident #13 on the morning of .
On at 10:00 AM Staff A stated, "Resident #13 had been living at the facility for several years and she was discharged from the hospital and had nowhere to go." Therefore, " on a humanitarian basis " they made a decision to readmit her.
A review of the facility's transfer control log revealed on at 11:25 AM Resident #12 was transferred to the hospital for . Resident #12 was re-admitted on at 7:10 PM.
Unclassified