STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968608	**07/17/2017**
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

A Wellness Monitoring Survey was conducted from through . Floridian Gardens with Extended Congregated Care and Limited Mental Health components, license # 12484 had deficiencies found at 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 provide care and offer personal supervision appropriate to the needs of residents, in order to prevent four out of four residents' (Resident #1, Resident #2, Resident #3 and Resident #4). Residents #1, #3, and #4 required precautions. The facility did not have adequate interventions in place to prevent for residents at risk.

Findings Include:

1)
A review of the resident record showed that Resident #1 was diagnosed with Parkinson's , , Acute Failure, , and . Health Assessment dated indicated was independent with eating; needed supervision with , toileting and transferring; and needed assistance with ambulation, bathing and dressing. The resident needed assistance with self-administration of medications. Per Health Assessment, the resident needed precautions. A facility incident report documented that on at 8:09 AM, he was taken to his breakfast and slipped while using the . He had pain and in his left wrist. He was transferred to the hospital.

Hospital record review showed that Resident #1 was admitted to the hospital on at 12:29 PM diagnosed with and Acute Kidney Injury after he down in the shower. He was alert and oriented times 2 (AAOX2). He had a of the end of the . He had a left radial surgery via regional nerve .

A facility Report review on showed that Staff B reported to administration that Resident #1 because the environmental services staff mopped his he was sleeping. Staff B stated that the resident slipped on the wet floor. Resident #1 was taken to the dining area to eat breakfast and laid him down in his . According to the facility's record of the examination of the video tape of the time surrounding the incident, the time line record showed that at 8:03:47 Staff B left the resident's Resident #1 in his wheelchair. At 8:08:55 Staff B returned Resident #1 into his . Staff B was leaning backwards and doing hands gestures at 8:09:59 as if to indicate that the resident had . The Administrator was notified at 8:11:27. Conflicting documentation in the internal incident report

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indicated that the resident before breakfast instead of after. There was a discrepancy between time line event, facility incident report and hospital record review.

2)
A review of Resident#2's record revealed the resident was admitted on . Health Assessment dated indicated she was diagnosed with , and . She was AAOX2 and was not under elopement risk/universal precautions. The resident was independent with ambulation, needed supervision with bathing and dressing, was independent with eating, supervision with self-care ( ), and independent with toileting and transferring. The resident needed assistance with self-administration of medications.

A review of Resident #2's observation log dated documented lower back pain and hip pain, the resident was transferred to the hospital on at 7:20 PM.

On at 2:45 PM Staff E stated, "Resident #2 at 3:00 AM, she refused to go to the hospital. When I got here that morning, I re-evaluated her and asked her if she had any pain. About 2 hours later she stated she had a small pain, I told her, an x-ray would be necessary. I called her son and told him I felt she needed to go to the hospital but she was refusing. The son agreed to send her to the hospital."

A review of the facility's adverse incident report dated documented at 3:20 AM the resident was found sitting on the floor of the rising from the toilet. Staff D was at the nurses' station and as she was doing rounds, found the resident on the . The resident refused to go to hospital and said she would sleep off the pain and eventually she informed staff that she changed her mind and was willing to go to the hospital. Her family members were informed.

A review of Resident #2's Hospital record revealed the resident primary history of , , Chronic Kidney , and , admitted to hospital on status post . The resident stated she tripped in her shower and but did not hit her head or lose . She was complaining of left hip and pelvic pain. No leg pain. She rated her pain on admission as an and reported limited range of motion because of pain. work showed chronic and chronic kidney . She was admitted to the floor for further workup and observation. XR pelvis demonstrated a left , and pubic rami with displacement of the medial segment. XR left femur demonstrated no acute or of the left femur and severe bone-on-bone at the medial aspect of the left knee.

Review of the facility's report on for Resident #2, documented that there were no witness the incident. The resident was heard going to the . Night Supervisor called the Administrator.

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The resident refused to go to hospital at first because she said she was going to sleep it off. Her son was called and said that if she didn't feel she needed to go to just let her sleep.

3) A review of Resident #3's record showed the resident was admitted on . Health assessment dated indicated he was diagnosed with , and . She is AAO x 2. Per Health Assessment the resident is under precautions risk, Universal Precautions. The resident needs assistance with ambulation, bathing, dressing, is independent with eating, and assistance with self-care ( ), toileting, transferring. The resident needs assistance with self-administering medications.

A review of Resident #3's observation log dated documented that caregiver had just placed the resident into bed and when she got back to the nurses station, the resident's called her because resident #3 had . Resident was from her head but was stable and oriented. 911 was called.

Adverse incident report dated documented the resident was transferred to the hospital. The resident was already tucked in bed as per Staff C. The resident's said that she got out of bed and tripped herself and .

On at 2:20 PM Resident #6 stated "The only thing I remember is that she tried to get up to go to the she in front of bed, I was on the other side. She did not have the bedrails on the bed. I called the staff because she ."

A review of Resident #3's observation log dated revealed. The Rehab Center was contacted about the resident condition.

A review of Resident #3's hospital record revealed, the resident , she says she was getting up to go to the she to the ground. She hitting her forehead. She had around her eyes. She did not think she lost . She had in the past. She denied any focal neurologic complaints at this time. She started with with exertion that was the main reason that the patient arrived to the emergency . At that time, the ER physician found the patient with hypoxemia, low .

A review of Resident #3's report on documented, Resident #6 said her sister/ had been put to bed but then got up while speaking and immediately . After Resident #6 , her sister/ called out to the west station and Staff C immediately went back to the resident's . It was Staff C's responsibility to put up her bed rails. Resident #6 said that the bed rails were not in

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place. A review of Resident #3's records revealed the resident had a bed rail order dated .

4)
Resident #4 was diagnosed with . Her health assessment dated indicated she was independent with eating; needed supervision with , toileting and transferring; and needed assistance with ambulation, bathing and dressing. Per Health Assessment, the resident was under precautions risk. The facility incident report document that on at 3:48 PM the resident wanted to walk around. She stood up from her chair, lost her balance and . She had a hematoma on her right side of her head. She was transferred to the hospital.

Hospital record review on showed that she was admitted on at 7:09 PM, diagnosed with a . She sustained an injury to the right side of her head after falling from a chair. Physical exam done on document Resident #4 was AAOX0, contracted, and had a right upper eyelid and two large circular above her right eye and an on the right lower leg on the lateral surface. The record document the hospital staff contacted Staff F on . "He stated that the resident is usually AAOX1. He did not note that she has many all over her body an on her right leg. The nurse denied that he noticed any over her right eye." Resident #4 was discharged to the facility on . She had a significant to her right forehead requiring and a to her right elbow.

Report showed Staff C was at the nurse station looking at her paperwork when Resident #4 at 3:48 PM. Staff C did not meet her 90 day probationary period as she did not follow facility policy and procedures.

On at 2:28 PM Resident #5 stated "I had a many months ago, but I do not remember. I have not had any recent , but my makes me become tired fast when I use the . At night, I go to the my own and the problem is that at night it is hard to find staff to help. Everything else is good, the meals are good. I get my medication every day. On the weekends, it is hard to find staff, but they will help me when I find them."

On at 2:30 PM Staff E "Stated Staff C no longer works here she was let go, Staff D moved to New York, and Staff B left, her last day was yesterday."

On at 2:50 PM Interview with Staff E stated, "We do not have a written record of the events that happen. We do rounds every hour and we have records of that, but there is nothing written by the staff recording the incidents that happened."

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Class II