STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967037	**06/29/2017**
NAME OF PROVIDER OR SUPPLIER **BERMUDEZ SENIOR CARE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **5301 SW 162 PLACE** **MIAMI, FL 33185**	

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

0000 - Initial Comments

A Standard Biennial Survey was conducted on . Bermudez Senior Care with Limited Mental Health service component, license # 11117, had deficiencies 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 provide care and offer personal supervision appropriate to the needs of residents, in order to prevent resident's for one out of six residents (Resident #1).

Findings Include:

A review of Resident #1's record documented that the resident was admitted to the facility on and has a diagnoses of late effect of CVD, functional decline, and bedridden. The Health Assessment dated indicated she required total assistance with the activities of daily living. The progress notes documented that on she slipped from the chair and hit her head. The staff called an ambulance and she was transferred to the hospital. On she slipped from her wheelchair and hit her hand. She refused to go to the hospital. On the next day she was sent to the hospital because her hand was and red. On she stood up from her wheelchair and . She hit her left leg and hand. Her son was notified and he refused to send her to the hospital. She was sent to the hospital on because she had pain.

On at 3:15 PM, the Administrator stated that Resident #1 never , she slipped from her chair.

A review of Resident #1's record showed that there was no documentation of any intervention created to minimize Residens #1's .

Class III

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

Based on observation, record review and interview the facility failed to obtain a written physician's order for the use of a half bed rail for one out of six (Resident #6) sampled resident.

Findings included:

Observation on at 11:45 AM showed that Resident #6 had half bed rails attached to her bed.

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The resident was unable to remove the bed rail or get out of bed without staff assistance.

A review of Resident #6's record showed that there was no written physician's order for the use of half bed rails.

Interviewed on at 3:10 PM, the Administrator acknowledged the findings and she stated, "I do not have the physician's order for the half bed rail in her record."

Class III

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

Based on observation, record review, and interview the facility failed to maintain an accurate written work schedule.

Findings include:

Observation on at 11:28 AM showed Staff B and D were caring for the residents and providing personal services to them.

Staffing schedule review showed Staff B scheduled to be in the facility 7 AM-7 PM; Staff C scheduled to be at the facility from 7 PM-7 AM, and Staff A scheduled to be on call.

Interviewed on at 3:10 PM, the Administrator confirmed the findings.

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 and submit a 1 day initial adverse incident report and a 15 day full incident report to the agency for one out of six sampled residents (Resident #1).

Findings included:

A review of Residents #1's progress notes document that on , the resident slipped from the chair and hit her head. The staff called an ambulance and the resident was transferred to the hospital. On she slipped from her wheelchair and hit her hand. She refused to go to the hospital. Next

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day she was sent to the hospital because her hand was and red. On she stood up from her wheelchair and . She hit her left leg and hand. Her son was notified and he refused to send her to the hospital. She was sent to the hospital on because she had pain.

During an interview on at 3:15 PM, the Administrator stated, "I did not report the incidents to AHCA."

Class III

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

Based on observation, record review and interview, the facility failed to register the employees on its roster in the Background Screening Clearinghouse Database for one out of four sampled staff (Staff D) .

Findings Include:

Observation on at 11:28 AM showed Staff D was caring for the residents and providing personal services to them.

Staff record review showed Staff D was hired on .

A review of the Background Screening Clearinghouse Database showed that the facility did not register Staff D.

On at 3:10 PM, the Administrator confirmed that she did not register Staff D in the Background Screening Clearinghouse Database.

Unclassified