STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968608	07/26/2017

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 Monitoring Survey for checking residents' wellness was conducted on , 2017. Floridian Gardens with Limited Mental Health and Extended Congregate Care components, license # 12489 had the following deficiency identified at the time of survey:

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 Assisted Living Facility failed to submit the required adverse incident report within one business day after the incident and within 15 days of the incident when a resident 's 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, for one out of one sampled residents (#1) .

Findings included:

Review of Resident #1's progress note dated showed that Resident #1 arrived in the electric wheelchair complaining of pain. Resident #1 explained to facility that he bumped his foot into a tension wire of a telephone pole a away from the gym. A pedestrian called rescue. Rescue wrapped Resident #1's foot in ice and Resident #1 refused going to the hospital. The facility's Registered Nurse assessed the Resident upon his arrival back at the site, and called an ambulance service. Resident #1 went to the hospital. Progress note of revealed that the facility contacted to hospital and Resident #1 had an ankle and . Progress note revealed that Resident #1 had right deduction of with external fixation surgery.

In an interview on at 12:19 PM, the Assistant Administrator stated that Resident #1 had an incident on the way back from the gym. Resident #1 explained to the facility that on the way back from the gym the wheelchair stopped and the Resident . People on the street called the rescue but the Resident refused to go because the wheelchair did not fit in the truck. Resident #1 arrived at the facility crying, and staff called the ambulance service.

In an interview on at 12:23 PM, the Administrator stated that facility did not file an incident report within one business day after the incident and within 15 days of the incident.

Class III