STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911859	**07/21/2017**
NAME OF PROVIDER OR SUPPLIER **SENIOR RETIREMENT HOME, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **3033 SW 6 STREET** **MIAMI, FL 33135**	

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

0000 - Initial Comments

A compliant survey (CCR 2017007526) was conducted at Senior Retirement Home Assisted Living Facility from and concluded on . There were deficiencies at the time of the survey.

0004 - Licensure - Requirements - 58A-5.016 FAC

Based on record review and interview the facility failed to have an annual satisfactory fire inspection.

Findings included:

Record review found the last fire inspection for the facility was dated . The facility failed to have an annual satisfactory fire inspection.

Interview on at 12:25 PM Staff D stated , "we request the inspection. It was on hold due the city's waste department. Everything is resolved, we requested an fire inspection."

Class III

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, interview and record review, the facility placed a resident at risk by not following puree diet orders and failed to have an updated health assessment after a significant change for 1 of 7 sampled residents (Resident #2).

Findings included:

A review of Resident # 2's file revealed the most recent health assessment was dated and documented that the resident was independent with ambulation, toileting and transferring and needed supervision with bathing, dressing, eating and self care. In addition, this health assessment documented Resident #2's special diet instructions as low/no added salt.

In an interview with Resident #2's guardian on at 9:45 AM, the guardian stated that Resident #2 was admitted to the hospital on for . In an interview at this time, the guardian stated that Resident #2 had a (endoscopic) tube placement surgery on and then the resident was discharged to a rehabilitation facility on .

A review of Resident #2's file documented that the resident was discharged to the assisted living facility on , with a post-discharge plan of care that indicated the resident needed a puree diet and

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set-up/assist with activities of daily living.

In an interview with Staff D on at 2:15 PM, Staff D stated that they knew Resident #2 needed a new health assessment.

Class III

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

Based on record review and interview, the facility failed to contact the resident's health care provider after the resident exhibited a significant change for 1 of 7 sampled residents (Resident #2).

Findings included:

A record review of facility progress notes in Resident #2's file documented on , "Resident is stable. No significant changes. Continues to eat puree and [resident's] appetite is good."
A record review of facility progress notes in Resident #2's file documented on , "Resident is stable; no significant changes. [Resident] continues to eat well.

A review of Resident #2's weight record documented that the resident weighed 160 lbs (pounds) on , but this documentation was crossed out, with error written in parenthesis, and 144 lbs marked next to the original entry of 160 lbs.

A review of Resident #2 weight record documented that the resident weighed 162 lbs on , but this documentation was crossed out and 120 lbs written next to the original entry of 162 lbs.

A review of resident #2 weight record documented that the resident weighed 105 lbs on .

In an interview with the Administrator and Owner on at 2:10 PM, they stated that the facility did not have any policies to document weight changes nor policies regarding notification of the health care provider for changes in weight.

Class III

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

Based on observation, interview, and record review, the facility failed to provide a safe and decent living environment, free from and neglect and failed to treat a resident with respect and dignity for 1 of 7 sampled residents (resident # 2).

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Findings included:

A review of Resident #2's file revealed the most recent health assessment was dated and documented that the resident had precautions and universal precautions.

A review of Resident #2's file documented that the resident was discharged to the assisted living facility on , with a post-discharge plan of care that indicated the resident needed a puree diet and set-up/assist with activities of daily living.

In an observation on at 9:30 AM, an investigator from another state agency requested Resident #2 be weighed. Resident #2 was lying on a recliner in the living of the facility. Staff B slammed the foot rest of the recliner and grabbed Resident #2 to get up. Staff A and B did not provide any type of balancing support for Resident #2 while the resident was on the scale and stated that the resident "won't ". An investigator from another state agency observed Resident #2's balance was unsteady at this time and provided hands-on-assistance by stabilizing Resident #2. After the weight was documented, Resident #2 sat back in the recliner, with Staff A & B assisting the resident into the seat. Staff B then pointed to Resident #2's shouting at Resident #2, stating that the resident should go to the sleep, rather than sleep on the recliner. Resident #2 was observed in the recliner until the resident got up for lunch.

In an interview with Resident #1 on at 10:55 AM, Resident #1 stated that the facility staff had mistreated Resident #1 and Resident #2. In an interview at this time, Resident #1 stated that staff have yelled at Resident #2 and also have pushed Resident #2. Resident #1 stated that when he was at the facility, he tried to warn Resident #2, with hand signals, that the staff was going to harm Resident #2. Resident #1 and Resident #2 did not speak the same language.

Another female resident stated on after 1:00 PM that staff yelled at the residents and was rough.

In a lunch observation on at 11:45 AM, Resident #2 was given chicken soup, mixed vegetables, and jello. Resident #2 was unable to eat without assistance. Resident #2 tried to use a spoon to get the soup out of the bowl, but each time Resident #2 brought the spoon up to their mouth, the soup would off the spoon and the Resident would have a mostly empty spoon. Resident #2 repeatedly attempted to feed herself, by filling the spoon with soup, bringing the spoon to their mouth, the soup falling off the spoon and then the Resident trying to fill the spoon again with soup. Resident #2 ate one spoonful of the soup without assistance. After unsuccessful attempts with the soup, Resident

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#2 then tried to eat the jello, and Staff B grabbed the jello away from Resident #2 and yelled, "no, no no!". After the jello was taken away from the Resident's hands, Staff B assisted Resident #2 with eating the soup. Staff B took the spoon from Resident #2, filled it with soup and tried to put the spoon in Resident #2's mouth. Resident #2 backed away from Staff B when Staff B brought the spoon close to Resident #2's mouth. Resident #2 was unable to back away further from Staff B and Staff B put the spoonful into Resident #2's mouth. Staff B continued to put spoonful after spoonful into Resident #2's mouth, without time in between to allow the resident to swallow the previous spoonful completely. Resident #2 was observed struggling, having a difficult time chewing the food, as there was chunks of chicken and pieces of vegetables within the soup. Resident #2's food was not pureed. Resident #2 tucked her chin towards her neck to assist with her own swallowing. Agency intervention was required at this time, where Staff B was instructed to stop with the feeding to allow Resident #2 to completely swallow the food in her mouth. Resident #2 drank water at this time, and was continuing to attempt to chew the food in her mouth. Resident #2 walked away from the table on her own, without eating a majority of the lunch meal.

In an observation on . . . . at 1:00 PM, Staff D yelled at Resident #2, "you need to eat".

Interview with the Administrator and owner of the facility on . . . . at 2:10 PM. Both staff members denied that staff yelled or were in any way to residents after observations were revealed to the facility.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on observations, record review, and interview the facility failed to ensure that 1 of 4 (Staff D) sampled staff had evidence of a negative ( ) examination documented on an annual basis.

Finding included:

Observations on . . . . from 10:15 AM to 10:30 AM found Staff D interacting with residents.

Record review revealed Staff D's last negative examination was dated . . . . . Record review found the facility did not have any evidence of a negative exam for Staff D.

On at 11:57 AM Staff D stated she had the current statement at another facility. Staff D acknowledged the documentation was not in the facility.

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Class III

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

Based on observations, record review, and interview the facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period.

Findings included:

Observations on at 9:45 AM found Staff A and B in the facility. Further observations on from 9:45 AM to 2:00 PM revealed Staff C was not in the facility.

Record review revealed the staffing pattern showed Staff A worked 7:00 AM to 7:00 PM Tuesday to Sunday, Staff B 7:00 AM to 7:00 PM Monday to Saturday, Staff C 9:00 AM to 5:00 PM Monday to Friday, and Staff D 7:00 PM to 7:00 AM Sunday to Friday.

Interview on at 11:57 AM Staff D stated that Staff A worked at night in the facility and she comes in sometimes.

Class III

0163 - Records - Resident, Penalties for Alteration - 429.49 FS

Based on record review and interview, the facility failed to maintain resident records that were free of fraudulent alterations for 1 of 7 sampled residents (Resident #1).

Findings included:

A record review of Resident #1's hospital records documented that Resident #1 weighed 170 pounds on .

In a record review conducted by another State Agency investigator prior to , Resident #1's health assessment was completed and signed by the healthcare provider on . The face sheet of the original health assessment documented resident #1's weight as 150 pounds.

In a record review of Resident #1's health assessment on , the original face sheet of the health assessment was replaced with an additional face sheet that documented Resident #1's weight as 120 pounds.

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A record review of facility progress notes in Resident #1's file documented, "Resident is stable. No significant changes. Spoke with [another State Agency Investigator]. I explained that the weight written on the 1823 (health assessment) and on our chart was incorrect. I also explained that in order to prove he has not lost 30 lbs (pounds) in 3 months, would be to request medical records from [name] hospital. [Investigator] said she would request and get back to us."

In an interview with the Administrator and Owner on at 2:10 PM, they stated that the facility did not have any policies to document weight changes nor policies regarding notification of the health care provider for changes in weight.

Class III