STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910951	**08/21/2017**
NAME OF PROVIDER OR SUPPLIER **DIVINE LIVING IN HIALEAH LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **70 EAST 21ST STREET** **HIALEAH, FL 33010**	

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

0000 - Initial Comments

A Monitoring Survey was conducted on , 2017. Divine Living of Hialeah, License #7170, with Limited Mental Health component had the following deficiencies identified at the time of the survey:

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

Based on observations, record review, and interview, the facility failed to ensure that one out of seven sampled residents met continued residency criteria.

Findings included:

Observations on at 2:00 PM found Resident #5 lying in bed with additional padding placed under the resident. Resident #5 was not interviewable.

Record review revealed Resident #3 required total care with eating or .

During an interview on at 3:00 PM the Administrator confirmed the notes on the resident's condition was not updated. She also stated the facility would contact the doctor and see if the resident needed to go to the rehab.

Class III

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

Based on observation and interview, the facility failed to provide a safe and decent living environment for the residents.

Findings included:

During the facility tour on at 1:53 PM, both stairs located in the center of the facility given access to the second floor were observed each to have two chains and each gate was locked. Staff F was not able to open the gate due to the fact the locks needed to be break/cut in order for the gates to be opened which are serious issues in case of emergency.

During an interview on at 1:53 PM, Staff F stated " both gates are locked the same way, I cannot open them."

During the exit interview on at 3:34 PM, Staff A agreed to find an alternative safety method.

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Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on record review and interview, the facility failed to complete the elopement/wandering assessment for one out of seven sampled residents (Resident #3).

Findings included:

Record review revealed Resident #3 was admitted on . Further record review revealed Resident #3 was reported missing to law enforcement on . On Resident #3 was reported missing from the facility. The facility records show the facility did not have a completed elopement/wandering assessment completed. Despite the facility having a wandering and elopement policy and procedure that stated resident would assessed at admission.

Interview with the Administrator on at 3:15 PM, he stated that Resident #3 was discharged from the facility. The Administrator also confirmed the facility did not have a completed elopement assessment for Resident #3.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility failed to provide a safe living environment free of hazards for the residents and ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order.

Findings included:

On at 2:06 PM a towel was observed on the closet's floor.

During an interview on at 2:06 PM, Staff F stated "there is a leak from the women common area by the water fountain."

Observations on at 1:50 PM found the sofa's on the first floor near the kitchen had white plastic trash bags on the seat cushions on the red chairs.

Staff present during the tour acknowledged the sofa's cushions were covered by white plastic trash

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SUMMARY STATEMENT OF DEFICIENCIES
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bags.

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 maintain an updated employee roster in the Background Screening (BGS) Clearinghouse Database.

Findings included:

Record review of the facility's employee roster in the BGS Clearinghouse Database revealed that Staff C is listed as employee of the facility.

During and interview on at 2:47 PM, Staff B stated "Staff C was an employee here, but not anymore."

During the exit interview on at 3:34 PM, Staff A stated "I updated the roster today, just did it."

Unclassified