STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966547	R 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADA ALF INC	**683 NW 122 Place** **MIAMI, FL 33182**

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

0000 - Initial Comments

A complaint investigation second revisit survey (CCR#2017002266) was conducted from . Ada ALF License #10770 had the following deficiency found at the time of survey:

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on observations, record reviews, and interviews, the Administrator failed to maintain general oversight of the daily operation of the Assisted Living Facility, which had a census of six. The Administrator also failed to ensure that staff provided adequate resident supervision, and failed to provide or arrange for resident services in accordance with the resident's scheduled and unscheduled service needs for one out of seven sampled residents (#5). The administrator failed to have precautions in place for two of five sampled residents identified as needing precautions (#5 and #7). The facility failed to prevent one of seven sampled residents that result facial and scalp (Resident # 5). The facility failed to ensure that Resident #5 followed up with her physician. The Administrator failed to provide a therapeutic diet as physician order for one out of seven sampled residents that was diagnosed with ; the resident was eating regular food (#5).

Findings included:

1)
On at 12:00 P.M. observed Staff D and E caring for a census of six residents. At 12:07 P.M. observed a female Resident #5 sitting in a wood rocking chair asleep, head down, with a and on her forehead, purple left and right eyes, nose and cheeks.

During an interview on at 12:08 P.M., Resident #5 stated her name and said "I here in the house, in my ."

During an interview at 1:02 P.M. the Owner/caregiver stated Resident #5 was in her when she tried to get up from her bed she , it was around 12:30 P.M. She further stated "I don't remember the day. If you need it, I have to look up that information in her file." The owner stated staff noticed the because the sound of the impact against the floor and the resident screams at the time of the .

On at 1:18 P.M. during a tour with the owner, observed that # was occupied by Resident #5 and had a personal bed and without bed rails attached.

At 1:02 P.M. A.M. the Owner stated "I did not implement any incidents/ precaution policy and

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procedures". The Owner acknowledged she did not have any procedures in place to prevent residents' . She stated "they are old people and they will ." The Owner stated that the administrator is not available to be contacted, and she is the person that operate the facility.

A review of the assisted living facility's (ALF) policies and procedures showed that "the employee must be aware of the needs and care of residents. The proper supervision of resident and safety practices must be implemented by all employees. The administrator is in charge of the entire operation of the ALF and is responsible for all personnel supervision to assure that all the residents' needs are meet. This includes the conduct of the employees and assurance of the well being of the resident in the ALF."

During an interview on at 1:57 P.M., Staff D stated Resident #5 on Tuesday after 12:00 P.M. She stated "I heard the resident yelled and I run to her . When I got there I saw Resident #5 on the floor. With Staff E, I helped, we lifted her up from the floor and we called 911 and the owner." She further stated "we do not have precautions in place to prevent Resident #5 or any other residents from a ." Staff D stated Resident #5 ate regular food every day, for example: rice, beans and meats. She stated Resident #5 did not have a puree diet.

A review of Resident #5's record showed that she was a admitted to the facility on . Review of the resident health assessment form dated indicated the resident had diagnoses ( ), , ( ), , ( ), and . ( ) The resident needed special precautions to prevent , and also needed precautions. The resident needed assistance with all the activities of daily living (ADL) and had special diet instructions (no added salt) and other: puree diet, fortified cereal and diagnosis of . Further record review showed on progress note dated "Resident #5 went to get up to go to the 12:20 A.M., lost balance and she . We called 911 for first aid and she was transferred to the hospital to get medical attention."

On at 12:58 P.M. during lunch, observed Resident #5 eating regular food: stewed beef, white rice, salad.

A review of the Discharge Summary from a hospital showed that on at 2:24 A.M., Resident #5 was discharged, with summary instruction/diagnoses: facial and scalp . The exam showed that Resident had a (deep) around her face or scalp. Injuries around the face and that cause a lot of , especially around the eyes. Follow up with the following physician in 3 to 5 days.

At 1:45 P.M., the Owner stated that she did not take Resident #5 to have a follow up with a physician

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since she was discharged from the hospital.

2)

A review of the resident record showed that Resident # 7 was , was admitted on .
The health assessment done on revealed medical diagnoses of , ( ),
, type 2 , unspecified , , , , , , , , . According to the health assessment, the resident needed special and safety precautions. The resident needed supervision with all ADL's. On between 12:00 noon and 1:45 pm, observed that there were no precautions in place.

3) A review of the facility's recent citation history showed that in , 2017, another resident , had a black eye, and did not receive adequate intervention after the . No precautions were in place for the resident. A review of resident and facility records showed that the Administrator had not implemented any changes after this with injury, to ensure the future safety of residents.

Class II