STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966801	**09/29/2017**
NAME OF PROVIDER OR SUPPLIER **MARGREG FACILITIES CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **12412 SW 213 TERRACE** **MIAMI, FL 33177**	

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

0000 - Initial Comments

A complaint (CCR #2017007014) survey was conducted on September 25th, 2017 and concluded on September 29th, 2017. Margreg Facilities Corp with limited mental health component (license number 10954) had the following deficiencies identified 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 Assisted Living Facility failed to notifying the responsible party when a resident have a change in health status for one (#8) out of nine sampled residents.

Findings included:

Review of Resident #8's record revealed that there was no documentation that the resident's power of attorney or family member were contacted and informed about the resident's or that the resident was transferred to the hospital.

In an interview on 09/22/17 at 11:38 AM Resident #8's son revealed that facility did not call him or inform him when his mother .

In an interview on 09/25/17 at 10:18 AM Resident #8's sister revealed that facility did not call her. "I called her (Resident #8)'s cell phone but I could not speak to her."

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 Assisted Living Facility failed to limit physical restraints to half bed rails for three (#2, #4, and #5) out of nine sampled residents.

Findings included:

Observation on 09/25/17 at 7:26 AM revealed Resident #2 resting in bed in Room #2 with full bed rail up and a recliner chair covering the other part of the bed. The bed was against the wall and did not allow the resident to get out of bed. Further observations on 09/25/17 at 7:28 AM revealed Residents #4 and #5 resting in bed in Room #3 with full bed rails.

In an interview on 09/25/17 at 7:28 PM Resident #4 revealed the resident did not know how to put the bed rails down.

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Review of Resident #2's record revealed a doctor ordered half-bed rails on '17. Review of Resident #4's record revealed the doctor order for half-bed rails on '16. Review of Resident #5's record revealed there was no doctor's order for the use of bed rails.

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 Assisted Living Facility failed to submit the incident report within one business day after the incident and within 15 days of the incident to AHCA when resident (#8) 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 and when a resident (#7) from and days later out of nine sampled residents.

Findings included:

Review of Resident #7's record revealed that progress noted of 17 showed that on Resident #7 went out to and did not . Resident told the roommate the same day that will go to where his girlfriend. On the the , the resident was called and did not answer. Facility went to the and was informed that needed to wait 72 hours. On was done the . On the an came to the ALF and informed that the resident was .

In an interview on 09/25/17 at 7:31 AM the Administrator revealed Resident #7 . Resident #7 left the facility on a . The resident said that was going but did not . Administrator went that day to the and reported but they told him that needed to wait 72 hours. Administrator called back the on and the . A later or so an went to the facility and informed that the resident was .

Review of Resident #8's record revealed the facility completed an internal incident/accident report on at 8:30 AM. It showed Resident #8 in the bedroom after her morning bath. Resident had a slight the of the The appeared minimal without major . She was helped to a comfortable seat and asked about her status, to which she responded feeling completely normal without feeling any discomfort. She did not want to go to the hospital (refused) and claimed feeling good during the day, being completely conscious and eating well her meals without issues.

In an interview on 09/25/17 at 7:34 AM the Administrator revealed Resident #8 went to the hospital

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because the resident had a . That day after lunch, the resident started having difficulties and was send to the hospital.

In an interview on 09/25/17 at 7:35 AM the Administrator revealed Resident #8 earlier but got out and continued walking. The facility did not send the resident to the hospital or call 911. Resident #8 was ok. The resident was getting out of the bathroom; a staff was with resident because they just finished in the bathroom.

Review of facility's record revealed that facility did not file and submit an incident report to AHCA within 1 and within 15 days of the incident.

In an interview on 09/25/17 at 8:20 AM the Administrator revealed that facility did not completed adverse incident reports with the agency.

Class III

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

Based on record review and interview, the Assisted Living Facility failed to maintain the employment status of all employees within the clearinghouse and any changes in status must be reported within 10 business days.

Findings included:

Review Background screening database for providers showed that facility's employee roster was had Staff E as an active employee.

In an interview on 09/25/17 at 7:48 AM the Administrator revealed that Staff E stopped working in the facility by the end of August 2017.

Unclassified