STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968281	**11/14/2017**
NAME OF PROVIDER OR SUPPLIER **EL EDEN CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **10460 NW 129 STREET** **HIALEAH GARDENS, FL 33018**	

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

0000 - Initial Comments

A Standard Biennial Survey was conducted on , 2017 (Lic# 12202). El Eden Corp, with the Limited Mental Health component, had the following deficiencies identified at time of the survey:

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

Based on record review and interview, the facility failed to have an accurate health assessment for 1 out of 6 sampled residents (Resident # 2). The facility also failed to ensure that documentation of an interdisciplinary care plan was kept for residents receiving hospice and care for of four sampled residents (Residents # 2- 5).

Findings included:

Record review revealed that Resident #2's health assessment (dated) had a discrepancy with the resident's hospice. The hospice document (dated) stated that Resident # 2 had wounds on the right foot ( ) and two wounds on the sacral area ( ). However, the Resident #2's health assessment stated no , , and it did not reflect hospice care.

Interviewed on at 2:29 pm, Staff B and D confirmed that Resident #2 had a , , and she was under hospice care."

Record review revealed that Residents' 2, 3 and 5's files did not contain a current plan of care . Resident #5's hospice plan of care (dated)listed only medication services; however, it was not complete due to missing integumentary (skin) information.

Interview on at 1:00 pm revealed that Staff B confirmed that Residents 2, 3 and 5 did not have current care plan, and Resident #4's plan only had medication information.

Class III

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

Based on observation, record review and interview the facility failed to obtain a written Doctor's order for the use of a full bed rail for one of four (#2) sampled residents.

Findings included:

Observation on at 10:00 am revealed that Resident #2 had a full bed rail attached to her bed.

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A review of the resident's record revealed that Resident #2 did not have any written hospice physician's or order.

Interviewed on at 11:00 am, Staff B stated, "Resident # 2 had a full bed rail order from her physician, and it is from hospice." Further record review revealed that no documentation was present regarding Resident #2's physicians' order for full bed rails hospice.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observations and record review the facility failed to ensure that licensed personnel administer medications to one of four (#4) sampled residents.

Findings included:

Observation on at 10:30 am revealed that the Medication Observation Record (MOR) was signed by Staff C and D (1-14 of 2017) for the following medications: ,
100 mg and , 25 mg.

Record review revealed that Resident #4's health assessment (dated) reflected that Resident #4 needed assistance with self- administration of medication.

Interviewed on at 1:29 pm Staff D stated that she provided Resident #4's medications. Staff D also stated, "I put the pill in a little cup, and I control (Staff D's hand) Resident #4's hand toward her mouths. This is the only way she will do it. She cannot take it herself."

Class III

0085 - Training - Nutrition & Food Service - 58A-5.0191(6) FAC

Based on observation, record review and interview the facility failed to provide documentation of staff training in Nutrition and Food Service for one of five sampled staff (Staff E).

Findings included:

Observation on from 10:00 am - 12:00 pm revealed Staff E cooking and preparing lunch for

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Residents (1-8).

A review of the personnel record revealed that there was no documentation of a Nutrition and Food Service in-service within 30 days of hire for Staff E.

Interviewed on at 12:50 pm Staff B acknowledged that Staff E was missing her Nutrition and Food Service in-service.

Class III

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

Based on observation and interview the assisted living facility failed to maintain the environment free of hazards.

Findings included:

Observation on at 12:00 pm revealed Residents 6 and 7 having lunch on the back porch.

Observation on at 9:30 am 1:00 pm revealed:
The back porch ceiling was covered with a substance resembling dirt or dust.
Two broken wheelchairs, two discarded portable tanks, an machine, a mattress, a bed frame and four pillows and three broken tiles were on the porch.

Interviewed on at 11:00 am Staff B stated, "We rent this house and we were waiting for the owner to fix the tiles and the ceiling of the porch. However, we are going to fix everything."

Class III