STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966160	12/07/2017
NAME OF PROVIDER OR SUPPLIER **CELENA'S SENIOR CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **10601 SW 142 AVENUE** **MIAMI, FL 33186**	

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

0000 - Initial Comments

A Monitoring Survey for checking residents' wellness was conducted on , 2017 and concluded on , 2017. Celena's Senior Care with Limited Mental Health component, license # 10415 had the following deficiencies identified at the time of survey:

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

Based on observation and interview, the Assisted Living Facility failed to limit the use of physical to half-bed rails for three (#3, #4, and #6) out of eight sampled residents. The facility used furniture and a half bed rail to prevent residents from getting out of bed without staff assistance.

Findings included:

Observation on at 8:52 PM revealed that Residents#3 and #6 rested in their beds in # . Resident #6 had a wheelchair blocking the resident from getting out of bed. Resident #6's bed had a half-bed rail and a chest of drawers in front of it, blocking the resident from getting out of bed.

Observed on at 9:11 PM Resident #4 rested in bed in # and there was a chest of drawers blocking from getting out of bed.

In an interview on at 9:11 PM Staff C and D confirmed that they used furniture in front of the beds as a measure to prevent .

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on observation, interview and record review, the Assisted Living Facility to provide documentation of an up-to-date admission and discharge log listing the names of all residents. Two of eight sampled residents were not listed (Residents #7 and #8).

Findings included:

Review of Admission and Discharge Log revealed that Residents #7 and #8 were not included.
Observation on at 8:52 PM revealed that Residents#3 and #6 rested in their beds in # .

Observation on at 8:54 PM revealed that Staff B and C took care of eight residents. Resident #8 sat in the family TV.

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

Observed on at 9:03 PM showed Resident #5 rested in # with half-bed rail up.

Observed on at 9:09 PM Residents #2 and #4 rested in their beds in # .

Observed on at 9:13 PM that Residents #1 and #7 rested in beds in the rest area.

In an interview on at 8:56 PM Staff B stated, "there are eight patients."

In an interview on at 10 PM Staff E revealed that two residents went to the hospital and Administrator thought that they were not going to return to the facility but they did.

Class III

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SUMMARY STATEMENT OF DEFICIENCIES
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Z828 - Administrative Fines; Violations - 408.813(3) FS

Based on observation and interviews, the Assisted Living Facility exceeded its licensed capacity of 6 residents. The facility had a census of 8 residents (Residents #1-8).

Findings included:

Observation on at 8:52 PM revealed that Residents#3 and #6 rested in their beds in # .

Observation on at 8:54 PM revealed that Staff B and C took care of eight residents. Resident #8 sat in the family TV.

Observed on at 9:03 PM Resident #5 rested in # with a half-bed rail up.

Observed on at 9:09 PM Residents #2 and #4 rested in their beds in # .

Observed on at 9:13 PM that Residents #1 and #7 rested in beds in the rest area.

In an interview on at 8:56 PM Staff B stated, , "there are eight patients."

Observation on at 10 PM revealed that there were medicines in the facility's office for the eight residents.

In an interview on at 10 PM Staff E revealed that two residents went to the hospital and Administrator thought that they were not going to return to the facility but they did.

Unclassified